	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			TE SURVEY MPLETED
		495019	B. WING		C	
	ROVIDER OR SUPPLIER	495019		STREET ADDRESS, CITY, STATE, ZIP CODE	02/24/2022 SS, CITY, STATE, ZIP CODE	
	IE REHABILITATION & H	IEALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
E 000	Initial Comments		E OC	ю		
F 000	survey was conducte 02/24/22. The facility compliance with 42 C Requirement for Long	/ was in substantial CFR Part 483.73, g-Term Care Facilities. No ness complaints were ne survey.	F 00	10		
	survey was conducte 02/24/22. Corrections with 42 CFR Part 483 requirements. The Lit	s are required for compliance 3 Federal Long Term Care fe Safety Code survey/report aplaints were investigated				
F 561 SS=D	274 at the time of the		F 56	11		3/30/22
	promote and facilitate through support of re	right to and the facility must e resident self-determination sident choice, including but ts specified in paragraphs (f)				
	activities, schedules (waking times), health					
	DIRECTOR'S OR PROVIDER/3	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE 03/25/2

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/03/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/24/2022	
		495019	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 •=	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			729 KING ST LEXANDRIA, VA 22302		
(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 561	Continued From page	2 1	F	561			
	choices about aspect facility that are signific						
	with members of the o	ident has a right to interact community and participate in both inside and outside the					
	religious, and commu interfere with the right facility.	ident has a right to tivities, including social, nity activities that do not ts of other residents in the is not met as evidenced					
	Based on staff intervi record review and fac the course of a compl staff failed to ensure t make choices importa evidenced by staff pla device to prevent the	iew, family interview, clinical ility document review and in laint investigation the facility the resident was able to ant to the resident as acement of a Wander Guard resident leaving the nursing nts in the survey sample			F Tag 561 Self determination Corrective Action Immediate corrective action was taken removing the wander guard within minutes of the resident s request. The Nursing Manager expressed immediate apology to the resident upon removal of 2/5/22. On 2/6/22 The unit manager called the resident and again offered a	e on	
	The findings include: Resident #381 was admitted to the facility with diagnoses including surgical aftercare, respiratory failure with hypoxia, cardiopulmonary disease, malnutrition, bronchitis, intra-abdominal hemangioma, hypertension, and				apology. The Licensed staff responsibl for the resident and the supervisor received counseling and were re-educated for procedure for assessir and MD order retrieval prior to placing guard on a resident.	e	
	reference date 2/4/20	sessment with assessment 22, the resident scored erview for mental status and			Identification To ensure that no other residents were affected, all residents that had a wand guard in place were re-assessed to		

Facility ID: VA0277

If continuation sheet Page 2 of 104

		MEDICAID SERVICES				O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	PLE CONSTRUCTION		E SURVEY IPLETED	
		495019	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		02/24/2022	
				2729 KING ST			
WOODBII	NE REHABILITATION & H	IEALTHCARE CENTER		ALEXANDRIA, VA 22302			
(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 T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE	
F 561	Continued From page	e 2	F 56	31			
	psychosis, or behavionsheet listed the resident party/resident representationsheet the resident representation of the resident representation of the resident representation of the resident representation of the resident set of	ors affecting care. The face ent as the responsible entative. The resident n stay for skilled services.		ensure that it was appro Resident Representative an MD order was in plac non-compliance were ide	e consented, and e. No areas of		
	The State survey and certification agency received a complaint concerning violation of the resident's rights on 2/9/2022. The complainant alleged the resident's rights had been violated when facility staff placed a wanderguard on the resident to prevent the resident from going outside to smoke. Clinical record review revealed no documentation of safety concerns such as confusion, wandering, or unsteady gait. A Navigation Planning Update (care plan) note dated 2/2/2022 at 13:42 did not mention concerns with the resident's cognitive status or safety. The resident's care plan (printed 2/16/2022 at 12:54 PM) in the electronic record			Systemic change All licensed staff will part re-education on adminis guard system with emph evaluation, consent and resident rights. The onsi or his/her designee mus information prior to placi guard to ensure complia information on the 24-ho	tration of wander nasis on MD order and te Unit Manager t review all ng the wander nce and place the		
	smoking or list concer- resident from leaving surveyor expressed of care plan did not add Interdisciplinary Care- uploaded to the resid the miscellaneous tal- mention restricting re- placing restraints on			Monitoring The ADON (or her desig all new wander guard or 24-hour report to ensure evaluation, consent and areas of non-compliance immediately, and the clir counseling and re-educa made to the MD, resider and the DON. The ADOI Quarterly report of any a	ders and the proper MD order. Any e will be corrected nician will receive ation. Notifications nt representative, N will submit a area of		
	Status Note on 2/5/20 morning shift change lobby area waring a j if she is planning to g wanting to go outside	about facility protocol and		non-compliance to the C further discussion and re			

Facility ID: VA0277

If continuation sheet Page 3 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLI	E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			PLETED
		495019	B. WING			C 02/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST		
					ALEXANDRIA, VA 22302		
(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 561	second Health Status AM "Resident request advice> Resident ref and gave writer her C stated 'my Dr will be h me'. Resident is self(f continue to monitor." The surveyor interview (MDS) assessment no MDS nurse indicated intended to keep the n The Smoking risk did address the resident's to apply nicotine patches. for lack of intervention overcoming the desire resident who wanted The nurse caring for t during an interview or supervisor instructed guard on the resident trying to go outside, s	Shift supervisor notified." A Note on 2/5/2022 at 11:07 ted to leave against medical used to wear Wander Guard igarette lighter. Resident here at 2pm to discharge Responsible party). Will wed the minimum data set urse on 2/16/2022. The that the wander guard was resident from going outside. not address strategies to a desire to smoke other than hes and monitor compliance . There was no explanation hs to assist the resident in e to smoke or to safeguard a to smoke. the resident that day stated h 2/24/22 that the nursing the nurse to put a wander to keep the resident from o the nurse did. director of nursing were oncern with resident choice erviews concerning the	F	561			
F 578 SS=D		ntnue Trmnt;FormIte Adv Dir	F	578			3/30/22
		ht to request, refuse, and/or t, to participate in or refuse					

Facility ID: VA0277

If continuation sheet Page 4 of 104

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/03/202 RM APPROVEI IO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		BUILDING COM		TE SURVEY MPLETED
		495019	B. WING			C 2/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE		
WOODBIN	REHABILITATION & H	IEALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 578	formulate an advance §483.10(c)(8) Nothing construed as the righ the provision of medi- services deemed med- inappropriate. §483.10(g)(12) The fa- requirements specifie subpart I (Advance D (i) These requiremen inform and provide w residents concerning medical or surgical tra- resident's option, forr (ii) This includes a wr facility's policies to im and applicable State (iii) Facilities are perr entities to furnish this legally responsible fo- requirements of this s (iv) If an adult individu- time of admission and information or articula has executed an adva- may give advance dir- individual's resident r with State Law. (v) The facility is not a provide this informati- or she is able to rece Follow-up procedures	rimental research, and to a directive. g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or acility must comply with the ed in 42 CFR part 489, irectives). ts include provisions to ritten information to all adult the right to accept or refuse eatment and, at the nulate an advance directive. itten description of the nplement advance directives law. nitted to contract with other information but are still r ensuring that the section are met. ual is incapacitated at the d is unable to receive ate whether or not he or she ance directive, the facility rective information to the epresentative in accordance	F 578			

Facility ID: VA0277

If continuation sheet Page 5 of 104

				DI -		r –	IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· · ·	E SURVEY IPLETED
				_			С
		495019	B. WING			02/24/2022	
NAME OF P	ROVIDER OR SUPPLIER	·		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	E REHABILITATION & H	IEALTHCARE CENTER			729 KING ST		
				Α	LEXANDRIA, VA 22302		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From page	e 5	F 57	78			
	1.0	iew, clinical record review,	1.57	10	F Tag 578 Request/Refuse/Discontinu	P	
	and facility document	review, the facility staff			Treatment		
		e status for 2 of 40 residents					
		, Resident #180 and #275.			Corrective Action	b.	
	For Resident #180 ar	d not address code status.			Immediate corrective action was taken calling the family and the MD and	бу	
	physician's orders die	Thot address code status.			receiving orders for code status. Resid	ent	
	The findings included	1:			#180 had orders obtained on 2/16/22 a		
					resident #275 had orders obtained on		
	1. Resident #180 dia	ignosis list indicated			2/16/22.		
	diagnoses, which incl						
		Nontraumatic Intracerebral Hemorrhage, Chronic Respiratory Failure, Dependence on Respirator,					
				Identification			
	Persistent Vegetative			To ensure that no other residents have			
	Mellitus, Muscle Was Depressive Disorder,			been affected, all residents on the unit which residents #180 and #275 reside			
	Malignant Neoplasm				the orders audited to ensure that all	nau	
	manghant tooplaom				residents had orders for code status.	No	
	The most recent adm	iission MDS (minimum data			other areas of non-compliance were		
		sessment reference date) of			identified.		
	1/20/22 coded the res	sident as being in a					
	persistent vegetative	state.					
	On 2/16/22. survevor	reviewed Resident #180			Systemic Change		
		as unable to locate a current			All licensed staff will take part of		
		arding the resident's code			re-education on obtaining orders on		
	status.				admission the facility for Code Status.		
					The unit manager for the unit which #1		
		and received the facility			and #275 or his/her designee will revie		
		nced Directives" which read			all admission orders within 24 hours to		
		ctor of nursing services or ne attending physician of			ensure that proper orders have been obtained for Code Status. Any area of		
		that appropriate orders can			non-compliance will be immediately		
		e resident's medical record			corrected by calling the family and the	MD	
	and plan of care. The	e attending physician will not			for orders. The nurse that did not obta		
	be required to write o	rders for which he or she			orders on admission will receive		
	has an ethical or con	scientious objection".			counseling and re-education.		
	On 2/16/22 at 4:00 pr	m, surveyor met with the					

Facility ID: VA0277

If continuation sheet Page 6 of 104

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,)		DMPLETED	
					С		
		495019		· · · · · · · · · · · · · · · · · · ·		02/24/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
WOODBIN	NE REHABILITATION & H	IEALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JENCY)	(X5) COMPLETION DATE	
F 578	Continued From page	e 6	F 57	8			
		int administrator, and the		Monitoring			
		sing) and discussed the		The ADON or his/her d	esignee will audit		
	concern of Resident	#180 not having a current		20% of all new admissi	ons monthly on the		
	physician's order add	lressing their code status.		unit in which resident #			
	No further information	a regarding this concern was		resided to ensure that of were obtained for all ne			
		n regarding this concern was ey team prior to the exit		Any area of non-compli			
	conference on 2/24/2			immediately corrected I	by obtaining		
				orders. The clinician an	-		
		liagnosis list indicated luded, but not limited to		Manager will receive co re-education. The ADO			
		Sclerosis, Acute and Chronic		Quarterly report of any			
		Dependence on Respirator		non-compliance to the			
		tes Mellitus, Epilepsy, Heart		further discussion and i			
		ein-Calorie Malnutrition,		This will continue for a			
	Ulcer.	sion, and Sacral Pressure		months and thereafter of compliance is achieved will make a formal reco	l; The QAPI Team		
	The most recent adm	ission MDS (minimum data		the monitoring can con			
	set) with an ARD (as	sessment reference date) of		100% compliance.			
		resident a BIMS (brief					
		status) summary score of 15					
	intact.	ne resident was cognitively					
	On 2/16/22, survevor	reviewed Resident #275's					
	clinical record and wa	as unable to locate a current					
	physician's order rega status.	arding the resident's code					
		and received the facility					
		nced Directives" which read					
		ctor of nursing services or					
		ne attending physician of o that appropriate orders can					
		e resident's medical record					
		e attending physician will not					
	be required to write o	rders for which he or she					
	has an ethical or con	scientious objection".				1	

If continuation sheet Page 7 of 104

	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/03/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED C
		495019	B. WING		02/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 578	Continued From page	7	F 57	8	
F 580 SS=D	administrator, assista DON (director of nurs concern of Resident # physician's order add On 2/23/22, the DON copy of a physician's dated 2/16/22 at 4:57 No further information presented to the surv conference on 2/24/22 Notify of Changes (Inj CFR(s): 483.10(g)(14) §483.10(g)(14) Notific (i) A facility must imm consult with the reside consistent with his or representative(s) whe (A) An accident involv results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-thr clinical complications (C) A need to alter tree a need to discontinue treatment due to adve commence a new form (D) A decision to trans- resident from the facil §483.15(c)(1)(ii).	jury/Decline/Room, etc.))(i)-(iv)(15) eation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident in there is- ring the resident which as the potential for requiring ; ge in the resident's physical, ial status (that is, a , mental, or psychosocial eatening conditions or); atment significantly (that is, an existing form of erse consequences, or to n of treatment); or sfer or discharge the	F 58	0	3/30/22

Facility ID: VA0277

If continuation sheet Page 8 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/03/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495019	B. WING		C 02/24/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		729 KING ST LEXANDRIA, VA 22302	
(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 COMPLETION
F 580	all pertinent informatia is available and provi- physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite di §483.5) must disclose its physical configurat locations that comprise part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on staff interv and facility document failed to promptly con the resident represen in the resident's phys residents in the surve The findings include:	the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations - is not met as evidenced iew, clinical record review, review, the facility staff isult the provider and inform tative of a significant change ical status for 1 of 40 by sample, Resident #8.	F 580	F Tag 580 Notification of Change Corrective Action Immediate corrective action was taken prior to the survey by which on 1/26/22 facility staff communicated to the resid representative and MD and document in the resident chart that both parties v notified of the significant weight loss.	ent ed
	For Resident #8, the	facility staff failed to ovider and RR (resident		in the resident chart that both parties v	

Event ID: URQT11

Facility ID: VA0277

If continuation sheet Page 9 of 104

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/03/20 FORM APPROV OMB NO. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495019	B. WING		C 02/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	•
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302	
(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 T DEFICIE	ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE
F 580	21.8 pound weight los however, the provide until 1/26/22. Resident #8's diagno which included, but n and Atrophy, Respira Hypertension, Anoxic Vegetative State, Pro Osteomyelitis, Acute Unstageable Pressur The most recent quar set) with an ARD (ass 11/12/21 coded the re- impaired in cognitive making. Resident #8 extensive assistance being totally depende transfers, dressing, e The resident was coor feeding tube in which of total calories and 5 fluid intake. Resident #8's current person-centered plan area initiated 5/27/21 for nutritional decline NPO (nothing by mou- hospitalizations, and Resident receives 10 needs via enteral nut include in part "Monit	ignificant weight loss. A ss was identified on 1/07/22, r and RR were not notified sis list indicated diagnoses, ot limited to Muscle Wasting tory Failure, Essential Brain Damage, Persistent tein-Calorie Malnutrition, Kidney Failure, and e Ulcer of Sacral Region. terly MDS (minimum data sessment reference date) of esident as being severely skills for daily decision was coded as requiring with personal hygiene and ent on staff for bed mobility, ating, toileting, and bathing. led for the presence of a they received 51% or more io1 cc/day or more average comprehensive of care included a focus stating "Resident is at risk related to multiple wounds, uth) status, recurring unplanned wt. (weight) loss. 0% of estimated nutritional rition". Current interventions or & evaluate weight/weight RD (registered dietician),	F 58	To ensure that no other n affected, all residents wi weight loss (planned or n reviewed to ensure that resident representative, been notified. No other non-compliance were ide Systemic Change All registered dieticians a were re-educated to ensunderstanding that any s loss (planned or unplann shared with the resident representative and the M and documented in the r The Unit Manager of the resident #8 resides (or d all significant weight cha hours to ensure that if a unplanned significant weight loss identified, the MD and R Representative was noti documented in the chart non-compliance will be r RD and Nurse will be su counseling and re-educated Monitoring The ADON or designee for all significant weight loss unplanned) per month to Resident Representative notified and documentat record. Any area of nor be immediately corrected the Resident Representative the Resident Representative	th significant unplanned) were the resident, the and the MD had areas of entified. and licensed staff ure significant weight hed) must be , the resident MD within 24 hours resident chart. unit where lesignee) will audit nges within 24 planned or reight loss is esident fied and that it is . Any areas of resolved, and the bject to ation. will audit 20% of ses (planned or o ensure that the e and MD were ion in the medical n-compliance will d by notification of ative and the MD. it Manager will

Event ID: URQT11

Facility ID: VA0277

If continuation sheet Page 10 of 104

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		10. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		ĆO	MPLETED
					С	
		495019	B. WING		0	2/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	REHABILITATION & H	IEALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		
(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 APP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE
F 580	Continued From page	a 10	F 58			
	Resident #8's current an order dated 11/09, feeding formula) at 64 12:00 pm and down a "provides 1300 ml tot pro (protein) / 988 ml On 2/15/22 at 3:04 pm Resident #8 in bed ref feeding pump at 65 m respond to the survey Surveyor reviewed R weights in the clinical significant weight loss occurred in a 5 day s On 1/02/22 the reside and on 1/07/22 the ref Documented weights 12/13/21 135.8, 1/01/ 1/07/22 112, 1/19/22 weight of 113.4 was of Surveyor was unable provider or RR notific weight loss. A RD progress note of "Resident triggers for weight loss. Appears - 136 # (pounds) sinc months), now with a s	t physician's orders included /21 for Jevity 1.5 (tube 5 ml/hour for 20 hours, up at at 8:00 am. Order states cal volume / 1950 kcals/ 88 g H2O (water)". m, surveyor observed eceiving Jevity 1.5 via tube nl/hour. Resident did not yor's presence in the room. esident #8's documented I record and noted a s of 21.8 pounds which pan from 1/02/22 to 1/07/22. ent weighed 133.8 pounds esident weighed 112 pounds. surrounding the loss were: /22 133.8, 1/02/22 133.8, 114.7. Resident #8's current		submit a Quarterly report of any a non-compliance to the QAPI Tear further discussion and recommen This will continue for a minimum of months and thereafter until 100% compliance is achieved; The QAF will make a formal recommendati the monitoring can conclude base 100% compliance.	n for dations. of 3 PI Team on when	
	POC (plan of care)". weight following this I 1/19/22 and was 114	reight loss. RD to continue The next documented RD note was obtained on .7 pounds.				

If continuation sheet Page 11 of 104

	-	ID 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 LETED
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	(current body weight) index) 18.0 (underwei significant weight loss (unfavorable). Currer weight gain x 2 weeks weight fluctuations. F fluctuations r/t enteral (recommendations): continue active protei healing and weight st On 2/24/22 at 2:50 pr DON (director of nurs surveyor with a late e created on 2/23/22 at date of 1/26/22 2:11 p noted with a significan RR made aware of th On 2/24/22 at 2:58 pr #1 who stated Reside weekly and weights w stated the resident wa well. Surveyor requested a policy entitled "Chang or Status" which read 1. The nurse will noti physician or physician been a(an): d. significant change physical/emotional/me 4. Unless otherwise i nurse will notify the re- when:	note states in part "CBW 114.7 #, BMI (body mass ight). Resident triggers for a x 1 month and 6 months httly with favorable 2.7 # a. Resident noted with Resident at risk for weight nutrition""RD recs continue enteral as ordered, n r/t (related to) wound ability/gain". n, surveyor met with the ing) and DON provided ntry nursing progress note 2:14 pm for the effective orm stating "Resident was nt weight lose [sp]. MD and e above". n, surveyor spoke with RD ent #8 was being weighed vere stable. RD #1 also as tolerating tube feedings nd received the facility je in a Resident's Condition in part: fy the resident's attending n on call when there has in the resident's ental condition; nstructed by the resident, a esident's representative nt change in the resident's	F	580			

Facility ID: VA0277

If continuation sheet Page 12 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495019	B. WING				C 24/2022
NAME OF PI	ROVIDER OR SUPPLIER		l	S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580 F 584 SS=E	 will be made within two change occurring in the condition or status. On 2/24/22 at 4:35 provide addition of status. No further information of presented to the surver conference on 2/24/22. Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-(1) §483.10(i) Safe Environ The resident has a rige comfortable and home but not limited to receive supports for daily livin The facility must provide system. (i) This includes ensure possible. (ii) This includes ensure content of the independence and dodition of the independence and dodition. 	emergencies, notifications venty-four (24) hours of a ne resident's medical/mental n, survey team met with the nt administrator, and DON ncern of the delay in g of Resident #8's significant n regarding this concern was ey team prior to the exit 2. ble/Homelike Environment (7) onment. ght to a safe, clean, elike environment, including iving treatment and ig safely.		580			3/30/22
		eeping and maintenance maintain a sanitary, orderly,					

If continuation sheet Page 13 of 104

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/03/2022 // APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>			(X3) DATE	
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				2	2729 KING ST		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		4	ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 584	in good condition; §483.10(i)(4) Private of resident room, as spec §483.10(i)(5) Adequar levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain and 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observation document review, the a clean environment of survey sample (Resident whose rooms had a divisible on multiple sur For Resident #8, #62, brown substance was in their rooms. The findings included 1. Resident #8's diag diagnoses, which incl Muscle Wasting and A Essential Hypertension Persistent Vegetative	ior; ed and bath linens that are closet space in each actified in §483.90 (e)(2)(iv); te and comfortable lighting able and safe temperature ly certified after October 1, temperature range of 71 to maintenance of comfortable is not met as evidenced in, staff interview, and facility facility staff failed to ensure for 3 of 40 residents in the lent #8, #62, and #143) ried, light brown substance faces in their rooms. and #143, a dried, light is visible on multiple surfaces consis list indicated uded, but not limited to Atrophy, Respiratory Failure, in, Anoxic Brain Damage, State, Protein-Calorie	F	584	F Tag 584 Safe and Clean Environmen Corrective Action Immediate corrective action was taken intense cleaning of the areas of resider rooms #8, #62 and #143. The surveyo indicated that it looked fantastic. Identification To ensure that no other residents were affected, a survey of all rooms that tubo feeding is in use were inspected. Any room that was identified of spattered tu feeding or uncleanliness in any way we cleaned. Systemic Change The nursing and housekeeping team w	by nt r be be ere	
	Persistent Vegetative	-					

Facility ID: VA0277

If continuation sheet Page 14 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 05/03/202 RM APPROVEI NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	· · ·	TE SURVEY MPLETED C
		495019	B. WING)2/24/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	E REHABILITATION & H	FAI THCARE CENTER		2	729 KING ST		
HOODE				A	LEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 584	Continued From page	e 14	F	584			
	and Unstageable Pre				spills and hard to clean areas. Th	e	
	Region.				housekeeping director or designed		
	-				inspect 5 rooms per week on the u		
		terly MDS (minimum data			where residents #8, #62, and #14		
	, , ,	essment reference date) of			resident and tube feeding are beir	-	
		esident as being severely skills for daily decision			to ensure that there are no spills o uncleanly areas. If any non-comp		
		was coded as requiring			areas are identified, the area will b		
	0	with personal hygiene and			cleaned immediately.		
		nt on staff for bed mobility,					
		ating, toileting, and bathing.			Monitoring		
		ed for the presence of a			The Asst. Administrator or designed		
		they received 51% or more 01 cc/day or more average			each inspect 10 rooms randomly p month on the unit where residents		
	fluid intake.	of colday of more average			and #143 reside. Any areas found		
					non-compliance will be cleaned		
	On 2/15/22 at 12:07 p	om, surveyor observed			immediately and reported to the		
		ith Jevity 1.5 TF (tube			Administrator. The housekeeping		
		ging on a TF pole beside the			and/or the housekeeper for that a		
		mp was turned off at this ormula was liquid and light			receive counseling and re-educati The Asst. Administrator will submi		
	brown in color. Surve				Quarterly report of any area of	la	
		ried, light brown substance			non-compliance to the QAPI Team	n for	
		the head of the resident's			further discussion and recommend	dations.	
	-	e with dried drips down the			This will continue for a minimum o	of 3	
	wall from the ceiling.				months and thereafter until 100%		
	On 2/22/22 at 11,26 a	m currence cheer ad the			compliance is achieved; The QAP will make a formal recommendation		
		am, surveyor observed the espots of a dried, light			the monitoring can conclude base		
		he ceiling tiles at the head			100% compliance.		
		above the TF pole with dried					
		om the ceiling and a dried,					
	•	e was also present on the					
	base of the TF pole a pole.	nd on the floor near the TF					
		nd received the facility					
		ng and Disinfection of					
	Environmental Surfac	es" which read in part:					

If continuation sheet Page 15 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _			C	
		495019	B. WING				24/2022	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER			729 KING ST ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	CTION SHOULD BE COMPLET O THE APPROPRIATE DATE		
F 584	 9. Housekeeping sur tabletops) will be clear when spills occur, and visibly soiled. 10. Environmental suc cleaned) on a regular times per week) and visibly contaminated of areas will be cleaned visibly contaminated of On 2/23/22 at 4:11 pm DHK (director of hous resident rooms are clear once a day. On 2/24/22 at 8:09 and administrator and dire observations of the dr in Resident #8's room On 2/24/22 at approxis spoke with Housekee cleaned Resident #8's accompanied Housek room and all previous brown substance had No further information presented to the survic conference on 2/24/22 2. Resident #62's dia diagnoses, which incl Chronic Respiratory F Mellitus, Left Thigh M Encephalopathy, Pers 	faces (e.g., floors, ned on a regular basis, d when these surfaces are infaces will be disinfected (or basis (e.g., daily, three when surfaces are visibly I window curtains in resident when these surfaces are or soiled. In, surveyor spoke with the ekeeping) who stated eaned by housekeeping In, surveyor notified the tector of nursing of the ied, light brown substance in. Imately 2:15 pm, surveyor per #1 who stated they is room. Surveyor teeper #1 to the resident's areas of the dried, light been cleaned. In regarding this concern was ey team prior to the exit 2. gnosis list indicated uded, but not limited to failure, Type 2 Diabetes	F	584				

If continuation sheet Page 16 of 104

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495019	B. WING				_ 24/2022		
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		•		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302				
(X4) ID PREFIX TAG				ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 584	set) with an ARD (ass 11/21/21 coded the re- persistent vegetative coded as being totally mobility, transfers, dra personal hygiene, and coded for the presend they received 51% or 501 cc/day or more an On 2/15/22 at 4:26 pr Resident #62 in bed r (tube feeding) formula The Glucerna 1.2 TF brown in color. Surve brown substance on t down the TF pole. On 2/23/22 at 11:47 at dried, light brown sub #62's TF pump, at the floor to the upper left the bed, and dried dri behind the TF pump. Surveyor requested at policy entitled "Cleani Environmental Surface 9. Housekeeping sur tabletops) will be clean when spills occur, and visibly soiled. 10. Environmental sur-	ion, Post Traumatic dence on Respirator. terly MDS (minimum data sessment reference date) of esident as being in a state. Resident #62 was y dependent on staff for bed essing, eating, toileting, d bathing. The resident was ce of a feeding tube in which more of total calories and verage fluid intake. n, surveyor observed receiving Glucerna 1.2 TF a via pump at 60 ml/hour. formula was liquid and light eyor observed a dried, light the tube feeding pump and astance present on Resident e base of the TF pole, on the side of the bed and under ps were present on the wall and received the facility ing and Disinfection of ces" which read in part: faces (e.g., floors, aned on a regular basis, d when these surfaces are urfaces will be disinfected (or	F	584	4				
	cleaned) on a regular	rfaces will be disinfected (or basis (e.g., daily, three when surfaces are visibly							

Facility ID: VA0277

If continuation sheet Page 17 of 104

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	D: 05/03/2022 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE SURVEY COMPLETED	
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	soiled. 11. Walls, blinds, and areas will be cleaned visibly contaminated of On 2/23/22 at 4:11 pm DHK (director of hous resident rooms are cleaned once a day. On 2/24/22 at 8:09 and administrator and direct observations of the driner observations of the driner infarction, Cerebral Electronic Kidney Diseaned Hypertension, Chronic Heart Failure, and De The most recent quar- set) with an ARD (assond the re- impaired in cognitive sond making. Resident #14 totally dependent on sond dressing, eating, toiler bathing. The resider presence of a feeding	 I window curtains in resident when these surfaces are or soiled. an, surveyor spoke with the ekeeping) who stated eaned by housekeeping an, surveyor notified the ector of nursing of the ied, light brown substance m. aregarding this concern was ey team prior to the exit 2. agnosis list indicated uded, but not limited to paresis following Cerebral dema, Dysphagia, Acute type 2 Diabetes Mellitus, se Stage 3, Essential c Diastolic (Congestive) pendence on Respirator. terly MDS (minimum data essment reference date) of esident as being severely skills for daily decision 43 was coded as being staff for bed mobility, t use, personal hygiene, and t was coded for the tube in which they received calories and 501 cc/day or 	F	584			

Facility ID: VA0277

If continuation sheet Page 18 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/03/2022 MAPPROVED). 0938-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		LETED		
		495019	B. WING_				C 24/2022		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
WOODBIN	IE REHABILITATION & H			2	729 KING ST				
WOODBIN		EALINCARE CENTER		Α	LEXANDRIA, VA 22302				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	RECTIVE ACTION SHOULD BE COMPLE RENCED TO THE APPROPRIATE DAT			
F 584	Continued From page 18		F	584					
	On 2/15/22 at 3:16 pm Resident #143 in bed feeding) formula runn ml/hour. The Jevity 1 and light brown in cold dried, light brown sub pump, down TF pole, in the floor. On 2/23/22 at 11:58 at the dried, light brown #143's TF pump, dow the pole, and in the flo also observed with dr behind the TF pump. Surveyor requested a policy entitled "Cleani Environmental Surface 9. Housekeeping sur tabletops) will be clean when spills occur, and visibly soiled. 10. Environmental sur cleaned) on a regular times per week) and v soiled. 11. Walls, blinds, and areas will be cleaned visibly contaminated of On 2/23/22 at 4:11 pm DHK (director of hous	n, surveyor observed with Jevity 1.2 TF (tube ing via pump set at 65 .2 TF formula was liquid or. Surveyor observed a stance present on the TF at the base of the pole, and um, surveyor again observed substance on Resident in TF pole, at the base of bor. The substance was ied drips down the wall ind received the facility ing and Disinfection of wes" which read in part: faces (e.g., floors, ned on a regular basis, d when these surfaces are urfaces will be disinfected (or basis (e.g., daily, three when surfaces are visibly d window curtains in resident when these surfaces are or soiled. n, surveyor spoke with the							
	once a day. On 2/24/22 at 8:09 an administrator and dire	n, surveyor notified the ector of nursing of the							

If continuation sheet Page 19 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/03/202 FORM APPROVEI OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	(X3) DATE SURVEY COMPLETED	
		495019	B. WING		C 02/24/2022
	Rovider or supplier	EALTHCARE CENTER	2729	EET ADDRESS, CITY, STATE, ZIP COL NKING ST EXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 584	in Resident #143's ro No further information presented to the surv	ried, light brown substance om. n regarding this concern was ey team prior to the exit	F 584		
F 604 SS=D	CFR(s): 483.10(e)(1) §483.10(e) Respect a	Physical Restraints , 483.12(a)(2) and Dignity. ght to be treated with respect	F 604		3/30/22
	physical or chemical purposes of discipline	ht to be free from any restraints imposed for or convenience, and not esident's medical symptoms, 12(a)(2).			
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to			
	from physical or chen purposes of discipline	that the resident is free nical restraints imposed for or convenience and that			
	symptoms. When the indicated, the facility alternative for the lea	eat the resident's medical use of restraints is must use the least restrictive st amount of time and -evaluation of the need for			

Facility ID: VA0277

If continuation sheet Page 20 of 104

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/03/2022 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495019	B. WING		C 02/24/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
WOODBIN	E REHABILITATION & H	IEALTHCARE CENTER		729 KING ST NLEXANDRIA, VA 22302	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 604		e 20 Γ is not met as evidenced	F 604		
	record review and in a investigation the facili resident was free from required to treat the mas evidenced by staff Guard device to prevenursing unit for 1 of 4 sample (Resident #37). The findings include: Resident #381 was a diagnoses including a failure with hypoxia, or malnutrition, bronchit hemangioma, hyperte gastroesophageal ref Minimum Data Set as reference date 2/4/20 15/15 on the brief inter was assessed as with psychosis, or behavior sheet listed the resider party/resident represent intended a short-term. The State survey and received a complaint resident's rights on 2/ alleged the resident's when facility staff place.	dmitted to the facility with surgical aftercare, respiratory cardiopulmonary disease, is, intra-abdominal ension, and flux disorder. On the ssessment with assessment 022, the resident scored erview for mental status and hout signs of delirium, fors affecting care. The face ent as the responsible entative. The resident in stay for skilled services.		F Tag 604 Free of Physical Restrait Corrective Action Immediate corrective action was tak removing the wander guard within minutes of the resident □s request. Nursing Manager expressed immedia apology to the resident upon remov 2/5/22. On 2/6/22 The unit manage called the resident and again offere apology. The Licensed staff respon for the resident and the supervisor received counseling and re-educate procedure for assessing and MD or retrieval prior to placing the guard or resident. Identification To ensure that no other residents w affected, all residents that had a wa guard in place were re-assessed to ensure that it was appropriate for us Resident Representative consented an MD order was in place. No area non-compliance were identified. Systemic change All licensed staff will participate re-education, consent and MD order a resident rights. The onsite Unit Man or his/her designee must review all information prior to placing the wan guard to ensure compliance and pla	ken by The diate al on er d an hsible ed for der on a ere inder se, the d, and is of ander and ager der
	Clinical record review	revealed no documentation		guard to ensure compliance and pla information on the 24 hour report.	ace the

Facility ID: VA0277

If continuation sheet Page 21 of 104

CENTER	S FOR MEDICARE &				OMB NO.	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		ETED
		495019	B. WING		C 02/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 604	of safety concerns su or unsteady gait. A N (care plan) note date not mention concerns status or safety. The 2/16/2022 at 12:54 P did not address concerns smoking or list concerns resident from leaving surveyor expressed of care plan did not add Interdisciplinary Care uploaded to the resid the miscellaneous tak mention restricting re placing restraints on Nursing notes on 2/5/20 morning shift change lobby area waring a juif she is planning to g wanting to go outside explained to resident resident agreed and Resident is own RR. second Health Status AM "Resident request advice> Resident ref and gave writer her O stated 'my Dr will be me'. Resident is self(continue to monitor."	Avigation Planning Update d 2/2/2022 at 1:42 p.m. did s with the resident's cognitive resident's care plan (printed M) in the electronic record erns with safety regarding erns that would prohibit the the building. (Note: After the concern that the resident's ress smoking, a form titled eplan Smoking Risk was lent's closed record under b. This document did not esidents to the building or residents.) /2022 included a Health 022 at 7:15 AM "During resident noted sitting at the acket. Writer asked resident go outside. Resident voiced e for smoke. Writer about facility protocol and	F 604		Any rrected eceive lent ADON areas um for ue for a er until QAPI ndation	

If continuation sheet Page 22 of 104

	-	D 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			
			A. BUILDI	NG _			C		
		495019	B. WING			02/	24/2022		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302					
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	E ACTION SHOULD BE COMPLE TO THE APPROPRIATE DATE			
F 604	address the resident's to apply nicotine patches. for lack of intervention overcoming the desire resident who wanted The nurse caring for the during an interview or supervisor instructed guard on the resident trying to go outside, s The surveyor determines restrained for convent definition of position of facility policy Wander of: Policy Interpretation The staff will identify in harm because of unsa- elopement). 2. The s management system part of care. 3. The we device will be used in resident-specific inter management of unsa- The surveyor found in the resident had beer at risk due to the expiration to smoke and the resi- unable to make deciss The facility policy Use Statement- Restraints safety and well-being	a desire to smoke other than hes and monitor compliance There was no explanation his to assist the resident in e to smoke or to safeguard a to smoke. The resident that day stated in 2/24/22 that the nursing the nurse to put a wander to keep the resident from o the nurse did. The nurse did.	F	604					

Facility ID: VA0277

If continuation sheet Page 23 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/03/2022 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED C
		495019	B. WING			2/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	DE	
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 604	discipline or staff com falls. Policy Interpreta The definition of a res functional status of th device. If the resident in the same manner t given the resident's p restricts his/her typica or place, this device is Restraints may only b has a specific medica addressed by another AND a restraint is req symptom; b. protect th help the resident attait well-being. During record review surveyor was unable symptom being treate Wander Guard device members (MDS nurse reported the purpose the resident leaving th knowledge. The resid facility and make a fo unduly restrained indi capable of understand considered the device Facility staff did not a of a restraint device, o order, or contact the r discuss consent for re-	venience, or prevention of ation and Implementation 2. straint is based on the e resident and not the t cannot remove the device hat facility staff applied it hysical condition and this al ability to change position is considered a restraint. 5. be used if/when the resident al symptom that cannot be r less restrictive intervention quired to: a. treat the medical he resident's safety; and c. in the highest practicable and staff interview, the to discover a medical ed by placement of a e on the resident. Staff e and charge nurse) of the device was to prevent the nursing unit without staff dent's decision to leave the rmal complaint about being icated the resident was ding the situation and e to be a restraint. ssess the resident for need contact the physician for an resident's family contact to estraint. d director of nursing were oncern with resident restraint erviews concerning the	F 604			

Facility ID: VA0277

If continuation sheet Page 24 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		495019	B. WING		02	C 2/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 604	Continued From page	24	F 60)4		
F 655 SS=D	-		F 65	55		3/30/22
	Planning §483.21(a) Baseline (§483.21(a)(1) The fac implement a baseline that includes the instr effective and person- that meet professiona The baseline care pla (i) Be developed withi admission. (ii) Include the minimu necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (E) Social services. (F) PASARR recomm §483.21(a)(2) The fac 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 fac resident and their rep	care plan for each resident uctions needed to provide centered care of the resident al standards of quality care. In must- in 48 hours of a resident's um healthcare information care for a resident ted to- l on admission orders.				

Facility ID: VA0277

If continuation sheet Page 25 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/03/2022 RM APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · · ·	E SURVEY IPLETED
		495019	B. WING		0	C 2/24/2022
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP COE		
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 655	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 staff interv the facility staff failed baseline care plan in and person-centered	the resident. resident's medications and treatments to be acility and personnel acting	F 655	F 655 Baseline Care plan Corrective Action Immediate correction action v offer counseling and re-educa		
	to assist a resident w	ho smokes in coping with oking facility for 1 of 40		team members working with to offer and document interve cope with a resident that desi cigarettes to cope in a health that is a non-smoking campu	the resident entions to ires to smoke care setting	
	diagnoses including s failure with hypoxia, o malnutrition, bronchiti hemangioma, hyperte gastroesophageal ref Minimum Data Set as reference date 2/4/20 15/15 on the brief inte was assessed as with psychosis, or behavio sheet listed the reside party/resident represe intended a short-term The State survey and	ension, and lux disorder. On the seessment with assessment 22, the resident scored erview for mental status and nout signs of delirium, ors affecting care. The face ent as the responsible entative. The resident stay for skilled services.		Identification To ensure that no other residuaffected, all residents that has smoke or who were identified individuals who expressed a smoke had their care plans a ensure that interventions wer and in place regarding appro- residents to cope with living in non-smoking community. No non-compliance were identified Systemic Change Licensed staff members that unit where #381 resided and supervisors were re-educated and documenting in the plan	ve wishes to I as desire to udited to e updated aches for n a areas of ed. work on the the facility d on offering	

Event ID: URQT11

Facility ID: VA0277

If continuation sheet Page 26 of 104

		ND HUMAN SERVICES MEDICAID SERVICES			F	NTED: 05/03/2022 FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495019	B. WING			C 02/24/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STAT	TE, ZIP CODE	
WOODDI				2729 KING ST		
WOODBI	NE REHABILITATION & H	IEALIHCARE CENTER		ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 655	resident's rights on 2 alleged the resident's when facility staff pla resident to prevent th outside to smoke. A Navigation Plannin dated 2/2/2022 at 1:4 with the resident's ris resident's care plan (PM) in the electronic concerns with safety concerns that would leaving the building. A concern that the resid address smoking, a ff Careplan Smoking R resident's closed rece tab. The minimum da reported the facility's to address smoking the non-smoking facility. had been stored in the document listed Goa compliance with nico of smoking through m Nicotine Patch as ME resident compliance interventions were lis administration record patches were not adt 2/2, 2/3, and 2/5 and Nursing notes on 2/5/20 morning shift change lobby area waring a j	/9/2022. The complainant a rights had been violated ced a wanderguard on the he resident from going g Update (care plan) note 22 did not mention concerns ak for smoking. The printed 2/16/2022 at 12:54 record did not address regarding smoking or list prohibit the resident from After the surveyor expressed dent's care plan did not form titled Interdisciplinary isk was uploaded to the ord under the miscellaneous at set assessment nurse care plan did not allow staff because the facility was a The document uploaded hat nurse's files. The I:Resident will be in tine patch with no episodes text review Approaches: 1. D ordered 2. Monitor with nicotine patch. No other sted. The medication I documented the nicotine ministered (code 22) on 2/1, refused (code 2) on 2/4. /2022 included a Health 022 at 7:15 AM "During resident noted sitting at the acket. Writer asked resident go outside. Resident voiced	F 6	care plan regarding r the desire to smoke i healthcare facility. A identified as someon smoke will be review Manager or designed resident and assure offered. A list of resi submitted to the DOI Monitoring The MDS Director (o review all new reside unit where #381 resi within 48 hours to en interventions are in p non-compliance will immediately, and a r DON. The MDS Direc submit a Quarterly re non-compliance to th further review, discus recommendations. T minimum of 3 month 100% compliance is Team will make a for	in a non-smoking any resident that is ne who has a desire to ved by the Nurse e to speak to the interventions are idents will be N for review. or designee) will ents admitted to the ded will be reviewed neure that appropriate place. Any areas of be corrected eport submitted to the ector or designee will eport of any area of ne QAPI Team for ssion and This will continue for a s and thereafter until achieved; The QAPI mal recommendation can conclude based	

Facility ID: VA0277

If continuation sheet Page 27 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/03/2022 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONST		(X3) DATE COMF	SURVEY PLETED
		495019	B. WING _				C 24/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		2729 KIN			
				ALEXA	NDRIA, VA 22302		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 655 F 684 SS=E	explained to resident a resident agreed and r Resident is own RR. S second Health Status AM "Resident request advice. Resident refu and gave writer her C stated 'my Dr will be h me'. Resident is self(f continue to monitor." There was no explana to assist the resident is smoke or to safeguard smoke. The administrator and made aware of the co 2/16/22 during intervie resident's care plan. Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fur applies to all treatmen facility residents. Base assessment of a resid that residents receive accordance with profe practice, the compreh care plan, and the res This REQUIREMENT by: Based on staff intervi and facility document failed to follow physici	about facility protocol and eturned to the room. Shift supervisor notified." A Note on 2/5/2022 at 11:07 ted to leave against medical used to wear Wander Guard igarette lighter. Resident here at 2pm to discharge Responsible party). Will ation for lack of interventions in overcoming the desire to d a resident who wanted to d a resident who wanted to d a resident who wanted to d director of nursing were ncern with care planning on ews concerning the ation the comprehensive lent, the facility must ensure treatment and care in assional standards of ensive person-centered	F	F68 Cori	34 Quality of Care rective Action hediate corrective action was taken	Ьу	3/30/22

Facility ID: VA0277

If continuation sheet Page 28 of 104

		ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 05/03/20 M APPROVI D. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		495019	B. WING		C 02/24/2022		
NAME OF P	ROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP COL		-	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST			
0(0)5						()(5)	
(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 CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 684	Continued From page	e 28	F 684	L.			
	#92, #143, #180, and		1 001	notifying the physician(s) car	ina for		
				residents #8, #92, #143, #18	•		
	For Resident #8, the	facility staff failed to monitor		report that medications were			
		to the administration of		given without parameters. For	or residents		
	Midodrine HCL, a me	dication used to increase		#8, #92, #143, #180 and #27	5 new orders		
		2 separate occasions. The		were obtained for the medica			
		HCL was not administered		given with parameters. Resid			
	on two (2) separate o	occasions without a		representatives of residents			
	documented reason.			#143, #180 and #275 were n	otified.		
	For Resident #92, the	e facility staff failed to		Identification			
		re and/or heart rate prior to		In order to ensure that no oth			
	the administration of			were affected, the physician			
		eat high blood pressure and		residents in the facility were r			
		n 15 separate occasions.		ensure that medication order			
		ed to monitor blood pressure ation of Amlodipine Besylate,		required parameters had app orders in place to track the bl			
	-	treat high blood pressure,		and heart rate and require it f	-		
	on 13 separate occas			documented prior to administ			
		Siono.		Unit Manager for each unit a			
	For Resident #143, th	ne facility staff failed to		any areas of non-compliance			
		re and heart rate prior to the		identified, the attending phys			
	administration of Met	oprolol Tartrate, a		resident representative were	notified, and		
		eat high blood pressure and n 5 separate occasions.		a new physician order was ol	btained.		
		-		Systemic Change			
		ne facility staff failed to		Licensed staff will complete r			
		re and heart rate prior to the		on how to obtain and enter of			
	administration of Met	•		require parameters for blood			
		eat high blood pressure and n 4 separate occasions.		and heart rate. The Unit mar designee will audit 20% of all			
	prevent onest paill, 0	11 - Separate Occasions.		with parameters weekly to er			
	For Resident #275 th	ne facility staff failed to		parameters are being recorde			
		re prior to the administration		followed. Any area of noncol			
		medication used to increase		be corrected immediately by	•		
) separate occasions.		the MD and resident represent			
				reported to the DON. The sta			
	The findings include:			will be subject to re-education	n and		
				counseling.			

Facility ID: VA0277

If continuation sheet Page 29 of 104

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/03/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495019	B. WING		C 02/24/2022
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 684	Muscle Wasting and A Essential Hypertension Persistent Vegetative Malnutrition, Osteomy and Unstageable Pre- Region. The most recent quar- set) with an ARD (ass 11/12/21 coded the re- impaired in cognitive making. Resident #8 extensive assistance being totally depender transfers, dressing, e Resident #8's current an order dated 11/05/ 10 mg via PEG-tube hypotension hold for pressure) greater that A review of Resident the Blood Pressure S and the February 202 administration record was administered wit assessment of the re- within one (1) hour of administration time of 2/01/22 6:00 am, 10:00 pm; 2/03/22 6:00 am, 10:00 pm; 2/03/22 6:00 am, 10:00 pm; 2/03/22 6:00 am, 10:00 pm; 2/03/22 6:00 am, 2:00/22 6:00 am, 2:00	nosis list indicated luded, but not limited to Atrophy, Respiratory Failure, on, Anoxic Brain Damage, State, Protein-Calorie yelitis, Acute Kidney Failure, ssure Ulcer of Sacral terly MDS (minimum data sessment reference date) of esident as being severely skills for daily decision was coded as requiring with personal hygiene and ent on staff for bed mobility, ating, toileting, and bathing. physician's orders included /21 for Midodrine HCL tablet every 8 hours for SBP (systolic blood n 120. #8's clinical record including rummary, Progress Notes, 22 MAR (medication) revealed Midodrine HCL hout documentation of sident's blood pressure	F 68	4 Monitoring The ADON or designee will aud medication that require parame monthly to ensure that the para blood pressure or heart rate are followed. Any area of noncomp be corrected immediately by no the physician and the unit mana staff members would be subject re-education and counseling. An noncompliance will be corrected immediately by notification of th resident representative and rep the DON. The staff members w subject to re-education and cou Quarterly report of noncomplian sent to the QAPI team for review discussion, and recommendation will continue for a minimum of 3 and thereafter until 100% comp achieved; The QAPI Team will r formal recommendation when th monitoring can conclude based compliance.	tters meters for e being bliance will otification of ager. The t to ny area of d ne MD and orted to vill be unseling. A nce will be w, ons. This B months bliance is make a he

If continuation sheet Page 30 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/03/2022 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>′</i>		E CONSTRUCTION		PLETED
		495019	B. WING				C 24/2022
NAME OF PI	ROVIDER OR SUPPLIER			ε	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	2729 KING ST		
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER			ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	6:00 am, 2:00 pm, 10 2:00 pm, 10:00 pm; 2 2/15/22 6:00 am; 2/16 2/17/22 6:00 am, 10:0 2:00 pm, 10:00 pm; 2 10:00 pm. Resident #8's Februa documentation that th was held on 2/14/22 at documented reason at locate a correspondin administration. Midoo the MAR for 2/14/22 at administered or held, left blank. Resident #8's clinical documentation of at left readings, however, or above, the readings do of the scheduled adm HCL. Surveyor requested at policy entitled "Admin states in part "7. Med within one (1) hour of unless otherwise spect and after meals" and information is checked prior to administering medications; and b. V On 2/24/22 at 8:05 an administrator and DO discussed the concern Midodrine HCL withou	:00 pm; 2/13/22 6:00 am, /14/22 6:00 am, 10:00 pm; 6/22 6:00 am, 2:00 pm; 00 pm; 2/18/22 6:00 am, /19/22 6:00 am, 2:00 pm, /19/22 6:00 am, 2:00 pm, /19/20 6:00 pm, /19/20 fm, /10/20 fm,	F	684			

Facility ID: VA0277

If continuation sheet Page 31 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		495019	B. WING				C 24/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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)		(X5) COMPLETION DATE
F 684	DON who stated idea blood pressure when medication. On 2/24/22 at 2:42 pr surveyor and stated ti staff on administering parameters. No further information presented to the surv conference on 2/24/2 2. Resident #92's dia diagnoses, which incl Acute Respiratory Fa Respirator Status, Ty Disorder, Essential H Aphonia. The most recent adm set) with an ARD (ass	am, surveyor spoke with the illy the nurse should take the administering the n, the DON returned to the he facility was educating medications with n regarding this concern was ey team prior to the exit 2.	F	684			
	impaired in cognitive making with short-tern problems. Resident #92's curren included an active ord Metoprolol Tartrate ta time a day for Tachyc pressure) hold if BP lo rate) less than 60.	skills for daily decision m and long-term memory ht physician's orders der dated 1/21/22 for blet 25 mg via G-Tube one ardia/elevated BP (blood ess than 120 or HR (heart					
	A review of Resident including the Blood P	#92's clinical record ressure Summary, Progress					

Facility ID: VA0277

If continuation sheet Page 32 of 104

		ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/03/2022 AAPPROVED D: 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(.	(X3) DATE SURVEY COMPLETED C		
		495019	B. WING					24/2022	
NAME OF P	ROVIDER OR SUPPLIER	1		s	STREET ADDRESS, CITY, STATE, ZI	P CODE			
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER			729 KING ST				
	1			4	ALEXANDRIA, VA 22302				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIAT	E	(X5) COMPLETION DATE	
F 684	Continued From non	- <u>-</u>		004					
F 004	Continued From page		F	684					
		ary 2022 MAR (medication) revealed Metoprolol							
		tered without documentation							
		resident's BP and/or HR							
	within one (1) hour of administration time o								
		4/22, 2/06/22, 2/07/22,							
		0/22, 2/11/22, 2/13/22,							
	2/15/22, 2/17/22, 2/1	8/22, 2/19/22, and 2/20/22.							
	Resident #92 also ha	d an active order dated							
		ine Besylate tablet 10 mg via							
	PEG-tube one time a	day for Hypertension hold							
	for SBP (systolic bloc	od pressure) less than 100.							
	A review of Resident	#92's clinical record							
		Pressure Summary, Progress							
		ary 2022 MAR revealed							
		was administered without sessment of the resident's							
	BP within one (1) hou								
	administration time o								
		4/22, 2/06/22, 2/07/22,							
	2/08/22, 2/09/22, 2/1 2/17/22, 2/18/22, and	1/22, 2/13/22, 2/15/22,							
	2/11/22, 2/10/22, and								
ĺ	Resident #92's clinica								
		east daily blood pressure							
	readings and heart ra	ites, nowever, on the /e, the readings did not							
		nour of the scheduled							
	administration of Met	•							
	Amlodipine Besylate.								
	Surveyor requested a	and received the facility							
		nistering Medications" which							
		dications are administered							
		f their prescribed time,							
	uniess otherwise spe	cified (for example, before							

Facility ID: VA0277

If continuation sheet Page 33 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/03/2022 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION	(X3) DATE	
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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 684	prior to administering medications; and b. V On 2/24/22 at 8:05 ar administrator and DO discussed the concern Metoprolol Tartrate ar without assessing Re and/or heart rate on m February 2022. On 2/24/22 at 10:51 a DON who stated idea blood pressure when medication. On 2/24/22 at 2:42 pr surveyor and stated th staff on administering parameters. No further information presented to the surve conference on 2/24/22 3. Resident #143's di diagnoses, which incl Hemiplegia and Hemi Infarction, Cerebral E Respiratory Failure, T Chronic Kidney Disea Hypertension, Chronic Heart Failure, and De The most recent quar set) with an ARD (ass	"11. The following d/verified for each resident medications: a. Allergies to l'tal signs, if necessary". n, surveyor met with the N (director of nursing) and n of staff administering ad Amlodipine Besylate sident #92's blood pressure nultiple occasions during am, surveyor spoke with the lly the nurse should take the administering the n, the DON returned to the ne facility was educating medications with a regarding this concern was ey team prior to the exit 2.	F	684			

If continuation sheet Page 34 of 104

	-	ID HUMAN SERVICES				FORM	APPROVED
	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		495019	B. WING				C 24/2022
NAME OF PF	ROVIDER OR SUPPLIER			٤	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		ALEXANDRIA, VA 22302 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	• 34	F	684			
		skills for daily decision		004			
	-	43 was coded as being					
	totally dependent on s dressing, eating, toile	t use, personal hygiene, and					
	bathing.						
	Resident #143's curre	ent physician's orders					
		ed 12/24/21 for Metoprolol					
		one time a day related to on hold for SBP (systolic					
		than 110 or HR (heart rate)					
	A review of Resident	#143's clinical record					
		ressure Summary, Progress					
		ary 2022 MAR revealed as administered without					
	documentation of ass	essment of the resident's					
	BP and HR within one administration time or	e (1) hour of the scheduled n the following days:					
		7/22, 2/12/22, and 2/17/22.					
	Resident #143's clinic	al record included					
	documentation of at le	east daily blood pressure					
	readings and heart ra	ites, however, on the re, the readings did not					
	occur within one (1) h						
	administration of Meto	oprolol Tartrate.					
		and received the facility					
		istering Medications" which dications are administered					
	within one (1) hour of	their prescribed time,					
		cified (for example, before					
	and after meals" and information is checked	d/verified for each resident					
		medications: a. Allergies to					
	medications; and b. V	/ital signs, if necessary".					

Facility ID: VA0277

If continuation sheet Page 35 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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 684	On 2/24/22 at 8:05 an administrator and DO discussed the concern Metoprolol Tartrate wi #143's blood pressure occasions during Feb On 2/24/22 at 10:51 a DON who stated idea blood pressure when medication. On 2/24/22 at 2:42 pm surveyor and stated th staff on administering parameters. No further information presented to the surve conference on 2/24/22 4. Resident #180 diad diagnoses, which incl Nontraumatic Intracer Respiratory Failure, D Persistent Vegetative Mellitus, Muscle Wast Depressive Disorder, Malignant Neoplasm The most recent adm set) with an ARD (ass 1/20/22 coded the resp persistent vegetative Resident #180's curref included an order data	n, surveyor met with the N (director of nursing) and n of staff administering thout assessing Resident e and heart rate on multiple ruary 2022. m, surveyor spoke with the lly the nurse should take the administering the n, the DON returned to the ne facility was educating medications with regarding this concern was ey team prior to the exit 2. gnosis list indicated uded, not limited to ebral Hemorrhage, Chronic Dependence on Respirator, State, Type 2 Diabetes ting and Atrophy, Major Dysphagia, Aphonia, and of Prostate. ission MDS (minimum data tessment reference date) of tident as being in a state.	F	684	4		

Facility ID: VA0277

If continuation sheet Page 36 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		495019	B. WING _				C 24/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			729 KING ST LEXANDRIA, VA 22302		
(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 684	SBP (systolic blood pi HR (heart rate) less th A review of Resident ; including the Blood Pi Notes, and the Februa Metoprolol Tartrate wa documentation of ass BP and HR within one administration time or 2/02/22, 2/03/22, 2/09 Resident #180's clinic documentation of at le readings and heart ra occasions listed abov occur within one (1) h administration of Meto Surveyor requested a policy entitled "Admin states in part "7. Meto within one (1) hour of unless otherwise spec and after meals" and information is checked prior to administering medications; and b. V On 2/24/22 at 8:05 an administrator and DO discussed the concert	ressure) less than 120 and han 60. #180's clinical record ressure Summary, Progress ary 2022 MAR revealed as administered without essment of the resident's a hour of the scheduled h the following days: 0/22, 2/13/22, and 2/14/22. Fal record included east daily blood pressure tes, however, on the e, the readings did not our of the scheduled oprolol Tartrate. Ind received the facility istering Medications" which lications are administered their prescribed time, cified (for example, before	F	584			
	#180's blood pressure occasions during Feb On 2/24/22 at 10:51 a	e and heart rate on multiple ruary 2022. Im, surveyor spoke with the Ily the nurse should take the					

Facility ID: VA0277

If continuation sheet Page 37 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/03/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		E CONSTRUCTION	(X3) DATE	
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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 684	medication.	e 37 n, the DON returned to the	F	684	4		
		he facility was educating					
		n regarding this concern was ey team prior to the exit 2.					
	Amyotrophic Lateral S Respiratory Failure, D Status, Type 2 Diabet Failure, Severe Prote	iagnosis list indicated uded, but not limited to Sclerosis, Acute and Chronic Dependence on Respirator tes Mellitus, Epilepsy, Heart in-Calorie Malnutrition, ion, and Sacral Pressure					
	set) with an ARD (ass 2/04/22 assigned the interview for mental s out of 15 indicating th intact. Resident #275 extensive assistance	ission MDS (minimum data sessment reference date) of resident a BIMS (brief tatus) summary score of 15 e resident was cognitively 5 was coded as requiring with dressing and being n bed mobility, transfers, giene, and bathing.					
	times a day for hypote blood pressure) great	der dated 1/28/22 for 10 mg via PEG-tube three ension hold for SBP (systolic er than 120.					
		#275's clinical record ressure Summary, Progress ary 2022 MAR (medication					

Facility ID: VA0277

If continuation sheet Page 38 of 104

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/03/2022 MAPPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		PLETED
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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 684	administration record) was administered with assessment of the res within one hour of the time on the following of am; 2/02/22 8:00 am, 12:00 pm; 2/04/22 8:0 12:00 pm; 2/04/22 8:0 12:00 pm; 2/13/22 4:00 12:00 pm; 2/13/22 4:00 12:00 pm; 2/13/22 4:00 12:00 pm; 2/13/22 4:00 12:00 pm; 2/17/22 8:0 12:00 pm; 2/17/22 8:0 12:00 pm, 4:00 pm; 2 4:00 pm. Resident #275's clinic documentation of at le readings, however, or above, the readings d of the scheduled adm HCL. Surveyor requested a policy entitled "Admin states in part "7. Med within one (1) hour of unless otherwise spec and after meals" and information is checker prior to administering medications; and b. V On 2/24/22 at 8:05 an administrator and DO discussed the concert Midodrine HCL withou) revealed Midodrine HCL hout documentation of sident's blood pressure e scheduled administration occasions: 2/01/22 8:00 12:00 pm; 2/03/22 8:00 am, 00 am, 12:00 pm; 2/05/22 /07/22 4:00 pm; 2/08/22 /09/22 8:00 am, 12:00 pm; 20 pm; 2/14/22 8:00 am, 00 am, 12:00 pm; 2/16/22 00 am, 12:00 pm; 2/16/22 /19/22 12:00 pm; 2/20/22 cal record included east daily blood pressure in the occasions listed did not occur within one hour inistration of Midodrine and received the facility distering Medications" which dications are administered their prescribed time, cified (for example, before "11. The following d/verified for each resident medications: a. Allergies to /ital signs, if necessary". m, surveyor met with the N (director of nursing) and n of staff administering ut assessing Resident e on multiple occasions	F	684			

If continuation sheet Page 39 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/03/2022 MAPPROVED D. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>			· /	TE SURVEY MPLETED	
		495019	B. WING				C 24/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			729 KING ST ALEXANDRIA, VA 22302			
(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 684	Continued From page	9 39	F	684				
		am, surveyor spoke with the lly the nurse should take the administering the						
	surveyor and stated th staff on administering parameters. At 2:55 p nursing progress note stating "(physician na Midodrine order was n	om, the DON provided a e dated 2/24/22 1:13 pm me omitted) notified that						
F 755 SS=D	presented to the surve conference on 2/24/22	edures/Pharmacist/Records	F	755			3/30/22	
	drugs and biologicals them under an agreer §483.70(g). The facil personnel to administ	ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed						
	pharmaceutical servic that assure the accura dispensing, and admi biologicals) to meet th	es. A facility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and ne needs of each resident.						
		onsultation. The facility n the services of a licensed						

Facility ID: VA0277

If continuation sheet Page 40 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/03/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495019	B. WING		C 02/24/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	E REHABILITATION & H			2729 KING ST	
WOODBIN		EALINGARE CENTER		ALEXANDRIA, VA 22302	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 755	Continued From page	e 40	F 75	5	
	§483.45(b)(1) Provide	es consultation on all on of pharmacy services in			
		shes a system of records of n of all controlled drugs in able an accurate			
	order and that an acc is maintained and per This REQUIREMENT by: Based on staff interv and facility document	is not met as evidenced iew, clinical record review, review, the facility staff		F 755 Pharmacy Services □ Services/Procedures/Pharmacist	
	Oxybutynin was avail of 40 residents, Resid #380.Resident #7's p Oxybutynin was not a staff on 02/06/22. The	hysician ordered medication Idministered by the nursing e nursing staff documented acy." Resident #380's not administered on		Corrective Action Immediate corrective action was ta providing re-education for the licer team members that did not follow to correct procedure when a medicat not available for residents #7 and a The physician and pharmacy were notified.	nsed the ion is #380.
	The findings included	:		Identification To ensure that no other residents v	were
	1. This was a closed	record review.		affected an audit was conducted for identification of any medication that	or
		diabetes, and		unavailable. If any areas of non-compliance were found, the pharmacy and MD would be imme notified. The licensed staff would b subject to 1:1 re-education or cour	be
	Section C (cognitive p	patterns) of Resident #7's		Systematic Change	

Facility ID: VA0277

If continuation sheet Page 41 of 104

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I				PRINTED: 05/03/202 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495019	B. WING		C 02/24/2022
NAME OF PROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	
WOODBINE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
 with an ARD (assessing 11/09/21 included a B mental status) summary possible 15 points. Resident #7's compressible 15 points. Resident #7's compression of the focus area neurogo included, but were normedications as ordered. Resident #7's physical for "Oxybutynin Chlorn release 24 hour 10 M bedtime for BLADDEI was documented as a con 02/06/22 at 9:00 p documented a "22" or medication Oxybutynin eMAR a "22=Drug/Tradocumented a "22" or medication Oxybutynin eMAR a "22=Drug/Tradocumented "Oxybutynin eMAR a "22=Drug/Tradocumented "Oxybutynin was not a on 02/06/22, the DON procopy of the stat box liar revealed that this mean the stat box for administration of 02/06/22. 	mum data set) assessment ment reference date) of BIMS (brief interview for ary score of 15 out of a ehensive care plan included genic bladder. Interventions t limited to, administer ed. an orders included an order ide ER tablet extended G Give 1 tablet by mouth at R SPASM." The order date 11/02/21. #7's eMARs (electronic ation records) revealed that .m. the nursing staff in the eMAR for the in. Per the code on the eatment not available." in., the nursing staff yninThe medication is on 0.m., the DON (director of ware of that Resident #7's ivailable for administration	F 75	All licensed staff will complete re-education regarding the steps to when a medication is unavailable. night shift supervisor or designee w the charts to identify any medicatio is noted as unavailable and review ensure that proper steps are taken notification of pharmacy and MD. area of non-compliance will be rep the DON and the licensed staff me will receive counseling and re-educ Monitoring The ADON or designee will audit w 20% of all medications to ensure th medication marked as unavailable followed proper procedure. Any ar noncompliance will be reported immediately to the DON. The ADO submit a quarterly report of noncompliance for review, discuss recommendations. This will continu minimum of 3 months and thereaft 100% compliance is achieved; The Team will make a formal recomme when the monitoring can conclude on 100% compliance.	The will audit on that vio for Any orted to other cation.

If continuation sheet Page 42 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/03/2022 MAPPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		LETED
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	of their policy titled, "I This policy read in par contracted pharmacy, effort to ensure that a resident is available to event that a medication noted to be unavailable be dispensed, nursing pharmacy regarding to medicationObtain a unavailable medication No further information medication was provid conference. 2. Resident #380's fact which included but no chronic respiratory fai neoplasm of bronchus and hypertension. Resident #380's admit set) with an ARD (ass 02/10/22 assigned the interview for mental s section C, cognitive p resident is moderately Resident #380's comp reviewed and contain- is at risk for chronic p Process from S/P (sta Right Lung Cancer" Resident #380's clinic contained a physician month of February 20 "Dexamethasone Tab	Unavailable Medication." rt, "In conjunction with the the facility will make every medication ordered for the o meet their needsIn the on ordered for a resident is le near or at the time it is to g staff shallContact the he unavailable hold order for the in" a regarding the unavailable ded prior to the exit ce sheet listed diagnoses t limited to acute and lure, heart failure, malignant is or lung, atrial fibrillation, ssion MDS (minimum data sessment reference date) of e resident a BIMS (brief tatus score of 6 out of 15 in atterns. This indicates the y cognitively impaired. prehensive care plan was ed a care plan for "Resident ain r/t (related to) Disease atus post) Fall, Metastatic	F	755			

Facility ID: VA0277

If continuation sheet Page 43 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 05/03/2022 MAPPROVED 0: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í				LETED
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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 755	NEOPLASM OF UNS UNSPECIFIED BROM (C34.90)". Resident #380's eMA administration record 2022 was reviewed al read in part, "Dexame 1 tablet by mouth three MALIGNANT NEOPL PART OF UNSPECIF LUNG (C34.90)". This 02/21/22 for all three code "22" is the equiv Not Administered". Resident #380's nurse reviewed and contain "Effective Date: 2/21/ eMAR-Medication Add Dexamethasone Table mouth three times a con NEOPLASM OF UNS UNSPECIFIED BROM Medication pending do STAT box." and "Effect eMAR-Medication Add Dexamethasone Table mouth three times a con NEOPLASM OF UNS UNSPECIFIED BROM Medication pending do STAT box." and "Effect eMAR-Medication Add Dexamethasone Table mouth three times a con NEOPLASM OF UNS UNSPECIFIED BROM Medication is on orde Surveyor requested at medications located to supply. Dexamethasone	PECIFIED PART OF NCHUS OR LUNG R (electronic medication) for the month of February and contained an entry which ethasone Tablet 4 mg. Give be times a day related to ASM OF UNSPECIFIED IED BRONCHUS OR is entry was coded "22" on administration times. Chart alent of "Drug/Treatment e's progress notes were ed notes which read in part, (2022 13:40 ministration Note. et 4 MG. Give 1 tablet by lay related to MALIGNANT PECIFIED PART OF NCHUS OR LUNG (C34.90). elivery. None available in ctive Date: 2/21/2022 21:31 ministration Note. et 4 MG. Give 1 tablet by lay related to MALIGNANT PECIFIED PART OF NCHUS OR LUNG (C34.90). et 4 MG. Give 1 tablet by lay related to MALIGNANT PECIFIED PART OF NCHUS OR LUNG (C34.90). r."	F	75			

Facility ID: VA0277

If continuation sheet Page 44 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/03/2022 RM APPROVED IO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED C
		495019	B. WING		0	2/24/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 755 F 756 SS=D	which read in part, "P the contracted pharm every effort to ensure the resident is availab Procedure: 2. In the ordered for a resident near or at the time it i staff shall: a. Contact unavailable medication medication from the fa- medication dispensing c. Notify the physiciar medication, explain th date of expected available pharmacy. i. Obtain a prior order, or ii. Obtain a prior order, or ii. Obtain unavailable medication applicable." The concern of Resid being available for ad with the administration assistant administration a meeting on 02/24/2 Drug Regimen Review CFR(s): 483.45(c)(1)(1) §483.45(c) Drug Regi §483.45(c)(2) This re- of the resident's medi §483.45(c)(4) The ph	olicy: In conjunction with acy, the facility will make that medication ordered for ole to meet their needs. event that a medication it is noted to be unavailable s to be dispensed, nursing the pharmacy regarding the on. b. Attempt to obtain the acility's automated g system or emergency kit. In of the unavailable ne circumstances, report the lability, and provide the n(s) recommended by new order and discontinue in a hold order for the on. d. Notify the pharmacy, if ent #380's medications not ministration was discussed e staff (administrator, or, director of nursing) during 2 at 4:35 pm. w, Report Irregular, Act On (2)(4)(5) imen Review. ug regimen of each resident east once a month by a	F 75			3/30/22

Facility ID: VA0277

If continuation sheet Page 45 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/03/202 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495019	B. WING		02/24/2022
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/2-1/2022
WOODBII	NE REHABILITATION & H	EALTHCARE CENTER		29 KING ST .EXANDRIA, VA 22302	
(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)	
F 756	facility's medical direct and these reports mu (i) Irregularities included rug that meets the c (d) of this section for a (ii) Any irregularities r during this review mu separate, written report attending physician a director and director of minimum, the resident and the irregularity th (iii) The attending phy resident's medical rect irregularity has been taken be no change in the r physician should door the resident's medical §483.45(c)(5) The fact maintain policies and drug regimen review f limited to, time frames the process and steps when he or she identified requires urgent action This REQUIREMENT by: Based on interviews documents, the facilitit medication regimen re- addressed by a medic sampled residents, R The findings include: Resident #78's MRR	ctor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist st be documented on a ort that is sent to the nd the facility's medical of nursing and lists, at a tt's name, the relevant drug, e pharmacist identified. reviewed and what, if any, n to address it. If there is to nedication, the attending ument his or her rationale in I record. cility must develop and procedures for the monthly that include, but are not s for the different steps in s the pharmacist must take fies an irregularity that n to protect the resident. is not met as evidenced and the review of y staff failed to ensure eviews (MRRs) were cal provider for one (1) of 40	F 756	F 756 Drug Regimen Review Corrective Action Immediate corrective action was taken notification to the attending MD. Psychiatry examined the patient on 2/25/22 and addressed the drug review recommendations made by the pharmacist.	

Event ID: URQT11

Facility ID: VA0277

If continuation sheet Page 46 of 104

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		C	
		495019	B. WING		02/24/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	E REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		
(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 SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTIC	
F 756	Continued From page	e 46	F 75	6		
	record review on 2/24	1/22.		Identification		
				To ensure that no other residents v		
		oses included, but were not		affected, an audit was completed of		
		pressure, thyroid disorder, s disease, and lung disease.		the drug regimen reviews. Any dru regimen review that was found	g	
		s disease, and lung disease.		non-compliant was immediately		
	Resident #78's minim	num data set (MDS)		addressed by the attending physic	ian or	
		assessment reference date		designee.		
	(ARD) of 12/10/21, w	as signed as completed on				
		78 was assessed as able to		Systemic Change		
		and as able to understand		Copies of all drug regimen reviews		
		was assessed as having a		given to the Unit Manager after the		
	BIMS (Brief Interview	13 out of 15; this indicated		pharmacists makes a recommenda The Unit Manager or designee will		
		ognition. Resident #78 was		the attending physician to ensure of		
	assessed as requiring	-		notification. If there is any delay in		
		sing, toilet use, and personal		assessment, the DON and Medica	I	
	hygiene. Resident #7			Director will be notified for follow-u	р.	
	receiving antipsychot	ic medications.				
	The following informe	tion was found in a facility		Monitoring	4 200/	
		ition was found in a facility on Regimen Reviews" (this		The ADON or designee, will review of the recommendations made on		
	document was not da			where resident #78 resides. Any a		
	- "The consultant pha	•		non-compliance will be corrected		
		review (MRR) for every		immediately, and a report submitte	d to the	
		receiving medication."		DON and Medical Director. The A		
	-	R is to promote positive		will submit a Quarterly report of an	-	
	outcomes while minir	•		of non-compliance to the QAPI Tea		
	medication."	otential risks associated with		further discussion and recommend This will continue for a minimum of		
		a thorough review of the		months and thereafter until 100%	~	
		cord to prevent, identify,		compliance is achieved; The QAP	Team	
	report and resolve me	edication related problems,		will make a formal recommendatio	n when	
		d other irregularities"		the monitoring can conclude based	lon	
		ician documents in the		100% compliance.		
		he irregularity has been				
	address it."	any) action was taken to				
	auur033 it.					

Facility ID: VA0277

If continuation sheet Page 47 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495019	B. WING			C 02/24/2022	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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 756	Resident #78's clinica following "Pharmacy of 12/21/21 at 2:42 a.m. Review: Recommend relaxant, methocarbai quetiapine and risperi muscle relaxant medi risperidone are antips The following commu was found in Residen "PHYSICIAN RECOM 12/21/21. The inform - "This resident is reco Methocarbamol. Curri indicate that these dru the elderly, leading to sedation, and weakne effectiveness at dose questionable. Please following options: () Medication should responds well to this is the quality of the resid therapy outweigh the () Taper Methocarban form also included an to mark if they agree, responses. This "PHYSICIAN RE did not include inform "concomitant use of q No evidence was four medical provider was recommendation to re	I record included the Consultant" note dated : "Medication Regimen d re-evaluation of a muscle mol and concomitant use of done." (Methocarbamol is a cation. Quetiapine and cychotic medications.) nication of the above MRR t #78's clinical record on a IMENDATIONS" form dated ation on this form included: eiving the muscle relaxant, rent clinical guidelines ugs are poorly tolerated in anticholinergic side effects, ess. Additionally, their s tolerated by the elderly is consider one of the be continued, patient medication, and it improves dent's life. The benefits of risks of adverse effects. mol to discontinuation". This area for a medical provider disagree, or have other COMMENDATIONS" form ation about the uetiapine and risperidone." no or provided to indicate a notified of the MRR e-evaluation the uetiapine and risperidone."	F	756			

If continuation sheet Page 48 of 104

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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 756	RECOMMENDATION medical provider did r to either continue or t From the agree, disag medical provider sele that psychiatry follows was found or provided staff member had rev the 12/21/21 MRR red On 2/24/22 at 1:10 p. (DON) was interviewed 12/21/21 MRR. The I evidence that psychia recommendations. T "PHYSICIAN RECOM include the pharmacis "concomitant use of of was also discussed. On 2/24/22 at 3:03 p. provide evidence of p aforementioned MRR DON reported they has practitioner (NP) for p Resident #78's 12/21, the NP for psychiatry but were working to c acknowledge the MR the doctor as part of t RECOMMENDATION the medication conce pharmacy consultant The facility's Administ and Assistant Administ team on 2/24/22 at 4: psychiatry action on F	IS" form on 12/22/21. The not select from the options aper the methocarbamol. gree, or other options, the cted "OTHER" and wrote in a the resident. No evidence d to indicate a psychiatry iewed and/or acted upon commendations." m., the Director of Nursing ed about Resident #78's DON was asked for itry had acted on the he failure of the 12/22/21 IMENDATIONS" form to st's comments about the juetiapine and risperidone" m., the DON was unable to sychiatry acting on the recommendations. The ad telephoned the nurse sychiatry related to /21 MRR. The DON stated confirmed they were behind atch-up. The DON R information provided to he "PHYSICIAN IS" form did not include all rns documented in the	F	750			

Facility ID: VA0277

If continuation sheet Page 49 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495019	B. WING				24/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			729 KING ST		
				Α	LEXANDRIA, VA 22302		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756			F	756			
	was provided related						
F 758 SS=D	· ·	chotropic Meds/PRN Use (e)(1)-(5)	F	758			3/30/22
	affects brain activities processes and behav but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe resident, the facility m §483.45(e)(1) Reside psychotropic drugs at unless the medication specific condition as o in the clinical record;	hotropic drug is any drug that associated with mental for. These drugs include, drugs in the following ensive assessment of a nust ensure that nts who have not used re not given these drugs n is necessary to treat a diagnosed and documented					
	drugs receive gradua behavioral interventio contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs pu	effort to discontinue these					
	in the clinical record; §483.45(e)(4) PRN of	ndition that is documented and rders for psychotropic drugs 5. Except as provided in					

If continuation sheet Page 50 of 104

		ND HUMAN SERVICES				FORM): 05/03/202 1 APPROVE 9. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED		
		495019	B. WING			02/24/2022		
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•		
WOODBIN	E REHABILITATION & H	EALTHCARE CENTER						
				A	LEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIOI DATE	
F 758	Continued From page	e 50	F	758				
		attending physician or	•	100				
	prescribing practition							
		RN order to be extended						
		or she should document their						
		ent's medical record and						
	indicate the duration	for the PRN order.						
	§483.45(e)(5) PRN o	rders for anti-psychotic						
	-	4 days and cannot be						
		attending physician or						
	the appropriateness	er evaluates the resident for						
	This REQUIREMENT	Γ is not met as evidenced						
	by: Based on staff interv	view, clinical record review,			F Tag 758 🗆 Free from unnecessary			
		t review, the facility staff			Psychotropic Med/PRN Use			
	-	2) of 40 residents were free			5			
	of unnecessary psycl				Corrective Action			
		sident #92. For Resident			Immediate corrective action was taker	for		
		2, it was determined the			resident #92 by receiving an updated			
	facility staff failed to e				physician order for a stop date. Resid			
		tion orders were renewed			#90 was discharged from the facility of 2/20/22 and therefore all orders were	n		
	every 14 days by a m				discontinued.			
	The findings include:							
					Identification			
		agnoses included, but were			To ensure that no other residents were			
	not limited to: cancel	r, anemia, high blood lepression, respiratory			affected, an audit of residents receivin psychotropic medications on the unit	y		
	failure.	oprossion, respiratoly			where residents #90 and #92 resided	was		
					completed. If any psychotropic medica			
	Resident #90's minim	num data set (MDS)			order did not include a stop date, the			
	assessment, with an	assessment reference date			attending physician would be called			
	. ,	as signed as completed on			immediately to obtain a stop date.			
		#90 was assessed as able to						
	make self understood	and as able to understand			Systemic Change			
				I				
) was assessed as having a			All licensed staff on the unit where Resident #90 and Resident #92 reside			

Facility ID: VA0277

If continuation sheet Page 51 of 104

TATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	CO	MPLETED
		495019	B. WING			C 2/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		
(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 / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 758	Continued From page	e 51	F 75	58		
	moderate cognitive in was documented as of mobility, dressing, pe Resident #90 was do assistance with eating #90 was assessed as medications. The facility staff failed an 'as needed' psych for Resident #90. Re documentation include 0.5 mg to be given via every six (6) hours as order did not include clinical documentation documentation for thi continued for greater Resident #90's care p focus area: "Resident antidepressant medic disorder and Depress interventions for this f anti-anxiety medication [sic]. The following informat titled "Antipsychotic N document was not da - "Residents will not r psychotropic medication	npairment. Resident #90 depending on others for bed rsonal hygiene, and bathing. cumented as requiring g and toilet use. Resident a receiving antianxiety d to provide a stop date for otropic medication ordered usident #90's medical led an order for alprazolam a the resident peg-tube a needed for anxiety. This a stop date. Resident #90 n did not include s 'as needed' order to be than 14 days. blan included the following at use anti-anxiety and cations (related to) Anxiety sion". One of the focus area was to "Give ons ordered by physician" tion was found in a policy Medication Use" (this ited): eceive PRN doses of ions unless that medication a specific condition that is inical record." ue PRN orders for ions beyond 14 days		 obtaining an order for ps the physician to include days. The unit manager the unit where resident # #92 resided will audit all medications within 24 hd an appropriate stop date the physician. Any area non-compliance would b the physician. The nurs the order would be subje and re-education. Monitoring The ADON or designee audit of 20% of new orde psychotropics weekly. A non-compliance will be of physician to obtain new orders. A report of non- sent to the DON. The A quarterly report of non- sent to the DON. The A quarterly report of non- sent minimum of 3 months ar 100% compliance is ach Team will make a formal when the monitoring car on 100% compliance. 	a stop date of 14 or designee of #90 and resident psychotropic ours to ensure that a was included by s of be addressed to e that received ect to counseling will conduct an ers for Any area of discussed with the or clarification compliance will be DON will submit a compliance to the scussion and will continue for a nd thereafter until heved; The QAPI recommendation	

Facility ID: VA0277

If continuation sheet Page 52 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/03/2022 MAPPROVED). 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495019	B. WING			C 02/24/2022		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE				
F 758	(PRN is a medical ab meaning 'as needed'. Resident #90's medic (MAR) was reviewed Documentation indica administered at least alprazolam all but one (Resident #90's MAR did not have a dose o as being given.) The failure Resident # address a stop date for anti-anxiety medication facility's Administrator Assistant Administrator	breviation for a Latin phrase) ation administration record for 1/1/22 through 2/20/22. Ited the resident was one dose of the 'as needed' e (1) day during this time. documentation for 1/5/22 f the alprazolam recorded	F	758				
	Acute Respiratory Fai Respirator Status, Ty Disorder, Essential H Aphonia. The most recent adm set) with an ARD (ass 12/16/21 coded the re- impaired in cognitive making with short-terr problems. Resident # active diagnosis of an Resident #92 was add 12/09/21. Resident # orders included an ac	uded, but not limited to ilure, Dependence on pe 2 Diabetes, Anxiety ypertension, Dysphagia, and ission MDS (minimum data sessment reference date) of esident as being severely skills for daily decision m and long-term memory 492 was also coded for the						

Facility ID: VA0277

If continuation sheet Page 53 of 104

	-	ID HUMAN SERVICES				FORM	/ APPROVED
			(20) MU			OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
						с	
		495019	B. WING			02/	24/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	IE REHABILITATION & H	EALTHCARE CENTER		2	729 KING ST		
WOODBIN				Α	LEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
IAG	REGULATORY ONE		IAG		DEFICIENCY)		
F 758	Continued From page as needed for anxiety	e 53 v. This order did not include	F	758			
	a limitation of 14 days benzodiazepine used	s or less. Lorazepam is a to treat anxiety.					
		#92's February 2022 MAR					
		ation record) revealed the azepam 2 mg on 2/01/22					
	and 2/06/22.	azepani z nig on 2/01/22					
	A NP (nurse practitior 2/16/22 stated "Anxie Lorazepam tablet 0.5	,					
		nd received the facility					
		ychotic Medication Use" I. The need to continue					
	•	otropic medications beyond					
	14 days requires that	the practitioner document					
		tended order. The duration be indicated in the order".					
	administrator and DO discussed the concer	n, surveyor met with the N (director of nursing) and n of Resident #92 receiving sychotropic medication, licated in the order.					
	surveyor with a copy dated 2/24/22 9:36 ar	n, the DON provided the of an order for Resident #92 n for Lorazepam 2 mg via urs as needed for anxiety					
	presented to the surve conference on 2/24/2						
F 760 SS=E		f Significant Med Errors	F	760			3/30/22

Facility ID: VA0277

If continuation sheet Page 54 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/03/202 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495019	B. WING		C 02/24/2022
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, Z	IP CODE
WOODBIN	NE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 760	Continued From page	e 54	F	760	
	medication errors. This REQUIREMENT by: Based on staff interv review the facility staf residents were free of errors, Resident #249 #8, Resident #249 #8, Resident #249, th resident's blood press when it should have to failed to obtain blood administering the blood Amlodipine. For Resident #380, th the resident's blood p	ts are free of any significant is not met as evidenced iew and clinical record if failed to ensure 5 out of 40 f significant medication 0, Resident #380, Resident #275. the facility staff held the sure medication, Metoprolol, been administered, and pressure prior to bod pressure medication		F Tag D 760 Free of Errors Corrective Action Immediate corrective action residents #249, #380, # by notification of the phy resident representative. were currently at Woodb was obtained to ensure were included in the ord medication and a space appropriate blood press was set.	tion was taken for 8, #92 and #275 ysician and All residents that bine a new order that parameters ler for giving this to document the
	 three separate occasion. For Resident #8, the facility staff failed to follow physician's orders for the administration of Midodrine HCL, a medication used to increase blood pressure, on six (6) separate occasions. For Resident #92, the facility staff failed to follow physician's orders for the administration of Metoprolol Tartrate, a medication used to treat high blood pressure and prevent chest pain, on two (2) separate occasions. For Resident #275, the facility staff failed to follow the physician's orders for the administration of Midodrine HCL, a medication used to increase blood pressure, on five (5) separate occasions. 			In order to ensure that n are affected, an audit of that require parameters pressure or heart rate w area of non-compliance corrective action of notif physician and resident r place. A new order to e documentation of the blo heart rate was obtained. Systemic Change All licensed staff will cor re-education on how to o order for medications wi and what to do if the blo heart rate is out of the p	all medications for blood vere audited. Any immediate fication of representative took nsure proper ood pressure or mplete obtain a proper ith parameters ood pressure or

Facility ID: VA0277

If continuation sheet Page 55 of 104

		ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVI 10. 0938-03
TATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED
		495019	B. WING		0	C 2/24/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CC	DDE	
				2729 KING ST		
WOODBIN	E REHABILITATION & I	HEALTHCARE CENTER		ALEXANDRIA, VA 22302		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 760	Continued From pag	e 55	F 76	0		
				Unit Manager or designee w		
	The findings included	d:		new medications with paran		
	1 Resident #2/19's fa	ace sheet listed diagnoses		heart rate or blood pressure parameters are correctly in		
		ot limited to Type 2 diabetes		Unit Managers will audit 20%		
		e chronic kidney disease,		medications that require par		
	depression, insomnia	a, and hypertension.		weekly to ensure that orders		
				parameters are being follow		
		st recent annual MDS		of non-compliance the phys		
		with an ARD (assessment /26/22 assigned the resident		resident representative will I The licensed staff would be		
		ew for mental status) score of		counseling and re-education	•	
	•	ates that the resident is				
	cognitively intact.			Monitoring		
				The ADON or designee will		
		cal record was reviewed and		orders that require paramete	•	
		n's order summary for the 022 which read in part,		Any area of non-compliance physician and resident repre		
		e 5 mg tab. Give 1 tablet		notified. The licensed staff		
		every Mon, Wed, Fri, Sun		to 1:1 re-education and cou		
	related to ESSENTIA	-		DON will be notified. A qua	-	
		0). HOLD FOR SBP (systolic		non-compliance will be subr		
	. ,). Do not give prior to		QAPI team for review, discu		
	dialysis", and "Metop	ablet Extended Release 24		further recommendations. T continue for a minimum of 3		
		ablet by mouth one time a		thereafter until 100% compli		
	day every Mon, Wed	5		achieved; The QAPI Team v		
		RY) HYPERTENSION (I10).		formal recommendation whe		
		stolic blood pressure) <110,		monitoring can conclude ba	sed on 100%	
		Do not give blood pressure		compliance.		
	during dialysis treatn	treatment due to hypotension nent"				
		AR (electronic medication				
	administration record					
		ich read in part, "Amlodipine				
		Sive 1 tablet orally in the Wed, Fri, Sun related to				
	u	RY) HYPERTENSION (110).				

If continuation sheet Page 56 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG				
		495019	B. WING _			C 02/24/2022		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	•	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER						
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 760	HOLD FOR SBP (sys Do not give prior to di Succinate ER (extende Extended Release 24 by mouth one time a d Sun related to ESSENTIAL (PRIMAR HOLD FOR SBP (sys HEART RATE <60. D med prior to dialysis treatm time for the Amlodipine entry for Amlodipine v and documented as a remaining days. Char of "Hold". There was pressure recorded rel administration. The entry for Metopro 02/02/22, with a corre 114/68. Resident #289's blood reviewed and contain of 99/68 on 02/04/22 02/07/22 at 9:48 am, am, and 98/62 on 02/ Surveyor spoke with t nursing) on 02/24/22 Resident #289's medi pressure related to a and DON stated, "priot the medication". Surv pressure obtained in t	tolic blood pressure) <110. failysis", and "Metoprolol ded release) Tablet Hour 50 mg. Give 1 tablet day every Mon, Wed, Fri, RY) HYPERTENSION (I10). tolic blood pressure) <110, o not give blood pressure reatment due to hypotension ent" The administration he was listed as 8 pm. The was coded "5" on 02/04/22 administered on the t code "5" is the equivalent no corresponding blood lated to these times of blol was coded as "5" on esponding blood pressure of d pressure summary was ed blood pressure readings at 10:07 am, 99/68 on 98/62 on 02/09/22 at 9:58 18/22 at 9:56 am. the DON (director of at 11:00 am regarding ications and blood medication should be taken, or to the administration of reyor asked the DON if blood the morning was valid for a red in the evening and DON	F7	760				

If continuation sheet Page 57 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/03/2022 // APPROVED). 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495019	B. WING _				C 24/2022	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			729 KING ST ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 760	Continued From page	57	F7	760				
	The concern of not ch pressure prior to the a and administering the outside the physician discussed with the ad (administrator, assistanursing) on 02/24/22 No further information 2. Resident #380's fac which included but no chronic respiratory fai neoplasm of bronchus and hypertension. Resident #380's admi set) with an ARD (ass 02/10/22 assigned the interview for mental sisection C, cognitive p resident is moderately Resident #380's clinic contained a physician month of February 20 "Metoprolol Tartrate T by mouth every 12 ho (PRIMARY) HYPERT UNSPECIFIED ATRIA HOLD FOR SBP (sys HEART RATE <60" Resident #380's eMA	ecking the resident's blood administration of Amlodipine medication Metoprolol ordered parameters was ministrative team ant administrator, director of at 4:35 pm. was provided prior to exit. the sheet listed diagnoses t limited to acute and lure, heart failure, malignant s or lung, atrial fibrillation, ssion MDS (minimum data essment reference date) of e resident a BIMS (brief tatus score of 6 out of 15 in atterns. This indicates the v cognitively impaired. trail record was reviewed and 's order summary for the 22 which read in part, ablet 25 mg. Give 1 tablet ours related to ESSENTIAL						
	and contained and en "Metoprolol Tartrate T	try which read in part, ablet 25 mg. Give 1 tablet						

Facility ID: VA0277

If continuation sheet Page 58 of 104

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/03/2022 MAPPROVED D. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		LETED	
		495019	B. WING			C 02/24/2022		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE			
F 760	by mouth every 12 ho (PRIMARY) HYPERT UNSPECIFIED ATRIA HOLD FOR SBP (sys HEART RATE <60". T as administered on 02 corresponding blood 02/10/22 at 9 pm with pressure of 103/60, a a corresponding blood Surveyor spoke with II 02/24/22 at 11:00 am blood pressure medic medication should not the aforementioned d The concern of admin blood pressure medic the physician ordered with the administrative assistant administrative assistant administrative 02/24/22 at 4:35 pm. No further information 3. Resident #8's diag diagnoses, which incl Muscle Wasting and A Essential Hypertensic Persistent Vegetative Malnutrition, Osteomy and Unstageable Pres Region. The most recent quar set) with an ARD (ass 11/12/21 coded the ref	burs related to ESSENTIAL ENSION (I10); AL FIBRILLATION (I48.91) tolic blood pressure) <110, This entry was documented 2/05/22 at 9 pm with a pressure of 105/65, on a corresponding blood and on 02/14/22 at 9 pm with d pressure of 109/61. DON (director of nursing) on regarding Resident #380's ation. DON stated that the t have been administered on ates/times. histering Resident #380's ation, Metoprolol, outside parameters was discussed e staff (administrator, or, director of nursing) on was provided prior to exit. nosis list indicated uded, but not limited to Atrophy, Respiratory Failure, on, Anoxic Brain Damage, State, Protein-Calorie velitis, Acute Kidney Failure,	F	760				

Facility ID: VA0277

If continuation sheet Page 59 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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 760	making. Resident #8 extensive assistance being totally depende transfers, dressing, ea Resident #8's current an order dated 11/05/ 10 mg via PEG-tube e hypotension hold for S pressure) greater than A review of Resident a (medication administr Midodrine HCL was a greater than 120 on th 2/03/22 2:00 pm - BP 2/05/22 6:00 am - BP 2/10/22 2:00 pm - BP 2/10/22 2:00 pm - BP 2/10/22 2:00 pm - BP 2/20/22 2:00 pm - BP	was coded as requiring with personal hygiene and nt on staff for bed mobility, ating, toileting, and bathing. physician's orders included 21 for Midodrine HCL tablet every 8 hours for SBP (systolic blood n 120. #8's February 2022 MAR ation record) revealed dministered with a SBP ne following occasions: 129/81 138/62 124/70 130/78 136/70 132/77 nd received the facility istering Medications" which e following information is ach resident prior to tions: a. Allergies to /ital signs, if necessary". n, surveyor met with the N (director of nursing) and n of Resident #8 receiving SBP greater than 120 on sions. n, the DON returned to the he facility was educating	F	760			

If continuation sheet Page 60 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/03/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE	
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			729 KING ST ALEXANDRIA, VA 22302		
(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 760	Continued From page	9 60	F	760			
		n regarding this concern was ey team prior to the exit 2.					
	Acute Respiratory Fai Respirator Status, Ty	uded, but not limited to					
	set) with an ARD (ass 12/16/21 coded the re impaired in cognitive	ission MDS (minimum data bessment reference date) of esident as being severely skills for daily decision m and long-term memory					
	time a day for Tachyc						
	(medication administr Metoprolol Tartrate wa less than 120 on 2/02	#92's February 2022 MAR ation record) revealed as administered with a BP /22 at 9:00 am with a BP of t 9:00 am with a BP of					
	policy entitled "Admin states in part "11. Th checked/verified for e administering medica	-					

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _			
		495019	B. WING				C 24/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		2 A			
(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 760	Continued From page	9 61	F7	760			
	administrator and DO discussed the concern Metoprolol Tartrate or with BP less than 120 On 2/24/22 at 2:42 pr surveyor and stated to staff on administering parameters. No further information presented to the surve conference on 2/24/22 5. Resident #275's di diagnoses, which incl Amyotrophic Lateral S Respiratory Failure, D Status, Type 2 Diabet	n, the DON returned to the he facility was educating medications with n regarding this concern was ey team prior to the exit 2.					
	Ulcer. The most recent adm set) with an ARD (ass 2/04/22 assigned the interview for mental s out of 15 indicating th intact. Resident #275 extensive assistance totally dependent with toileting, personal hyg Resident #275's curre included an active or Midodrine HCL tablet	ent physician's orders					

Facility ID: VA0277

If continuation sheet Page 62 of 104

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495019	B. WING _				C / 24/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			729 KING ST LEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	blood pressure) great A review of the Reside MAR (medication adm Midodrine HCL was a greater than 120 on tt 2/02/22 4:00 pm - BP 2/06/22 12:00 pm - BP 2/16/22 4:00 pm - BP 2/16/22 4:00 pm - BP 2/20/22 8:00 am - BP Surveyor requested a policy entitled "Admin states in part "11. Th checked/verified for e administering medica medications; and b. V On 2/24/22 at 8:05 ar administrator and DO discussed the concern Midodrine HCL with a five (5) separate occa On 2/24/22 at 2:42 pr surveyor and stated tt staff on administering parameters.	er than 120. ent #275's February 2022 ninistration record) revealed dministered with a SBP ne following occasions: 131/75 P 132/66 130/80 121/70 123/66 nd received the facility istering Medications" which e following information is ach resident prior to tions: a. Allergies to <i>l</i> ital signs, if necessary". n, surveyor met with the N (director of nursing) and n of Resident #275 receiving SBP greater than 120 on isions. n, the DON returned to the he facility was educating	F 7	760			
F 761 SS=D	presented to the survice on ference on 2/24/22 Label/Store Drugs an CFR(s): 483.45(g)(h)(§483.45(g) Labeling of	ey team prior to the exit 2. d Biologicals	F 7	'61			3/30/22

Facility ID: VA0277

If continuation sheet Page 63 of 104

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/03/2022 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495019	B. WING		C 02/24/2022
	Rovider or supplier	EALTHCARE CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2729 KING ST ALEXANDRIA, VA 22302	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 761	professional principle appropriate accessor instructions, and the of applicable. §483.45(h) Storage of §483.45(h)(1) In acco Federal laws, the faci biologicals in locked of temperature controls, personnel to have acc §483.45(h)(2) The fac locked, permanently storage of controlled the Comprehensive E Control Act of 1976 a abuse, except when the package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observation document review, the drugs and biologicals 1 of 6 facility units, TO For the TCU Unit, the unattended medication medications and left a unattended on top of The findings included On 2/17/22 at 9:10 ar	e with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to the facility uses single unit titon systems in which the imal and a missing dose can is not met as evidenced n, staff interview, and facility e facility staff failed to store in locked compartments on CU. facility staff failed to lock an on cart containing resident a bottle of Vitamin C 500 mg the medication cart.	F 761	F Tag 761 Label/Store Drugs and Biologicals Corrective Action Immediate corrective action was tak lock the medication cart. The nurse left the cart briefly was re-educated security of all medication and ensur that the medication cart is locked ar secured prior to walking away from Identification To ensure that no other residents we affected, all medication carts on the	e who on the ing nd it.

Event ID: URQT11

Facility ID: VA0277

If continuation sheet Page 64 of 104

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,) ´co	MPLETED
						С
		495019	B. WING		0	2/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
WOODBIN	E REHABILITATION & F	EALTHCARE CENTER		2729 KING ST		
				ALEXANDRIA, VA 22302		
(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	(X5) COMPLETIO DATE
F 761	Continued From page	<u>- 64</u>	F 76	1		
	hallway of the TCU U		170	unit were inspected to en	sure that all	
		a multi-dose bottle of Vitamin		medication carts were loc		
		urveyor remained beside the		was not at the cart. All ot		
	U	oproximately three (3)		found to be secured.		
		ensed practical nurse) #1				
		lent room into the hall. LPN		Systemic Change		
		vas not normal practice to		The licensed nurses on th	e unit where the	
	leave the medication	cart unlocked but stated		cart was found unlocked	were	
	they had ran into a re	esident's room to check an		re-educated on securing a	and locking	
	alarm. LPN #1 place	d the bottle of Vitamin C into		medication carts when wa	alking away. The	
	the medication cart a	nd locked the cart.		Unit Manager or designee	e will be	
				responsible for making ro	unds on the unit	
	Surveyor requested a	and received the facility		randomly weekly and che	cking 5 carts. If	
		ge of Medications" which		any cart is found to be un		
		s and biologicals used in the		will be secured immediate		
	-	ocked compartments under		that is assigned to that ca		
		ight and humidity controls.		counseling and re-educat	-	
	Only persons authori			medication carts. Any are		
		ns have access to locked		non-compliance will be re	ported to the	
		Compartments (including,		ADON.		
		wers, cabinets, rooms,		NA		
		nd boxes) containing drugs		Monitoring		
		cked when not in use.		The ADON or designee w		
	Unlocked medication	s carts are not left		on the unit where the cart		
	unattended".			unlocked/unsecured. If a		
	On 2/21/22 at 1.25 m	m survey team mat with the			•	
	-	m, survey team met with the ant administrator, and the		found to be unlocked, it w locked/secured immediate		
		in administrator, and the oncern of		in charge of the cart will re		
		nlocked medication cart with		counseling and re-educat		
	-	tablets on top of the cart		will submit a Quarterly rep		
	unattended in the hal	-		of non-compliance to the		
				further discussion and rec		
	No further information	n regarding this issue was		This will continue for a mi		
		ey team prior to the exit		months and thereafter un		
	conference on 2/24/2			compliance is achieved; 1	The QAPI Team	
				will make a formal recomm		
				the monitoring can conclu	ide based on	
	1		1	100% compliance.		1

Facility ID: VA0277

If continuation sheet Page 65 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 05/03/2022 RM APPROVED O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495019	B. WING			02	2/24/2022
	ROVIDER OR SUPPLIER	EALTHCARE CENTER	1	2	TREET ADDRESS, CITY, STATE, ZIP CODE 729 KING ST ALEXANDRIA, VA 22302		
(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)	3E	(X5) COMPLETION DATE
F 772 SS=D			F	772			3/30/22
	laboratory services to residents. The facility and timeliness of the (iv) If the facility does services on site, it mu obtain these services meets the applicable this chapter. This REQUIREMENT by: Based on staff interv and facility document failed to obtain physic for 1 of 40 residents in Resident #180. For Resident #180, th obtain a sputum cultur blood for testing. The findings included Resident #180 diagnor which included, not lin Intracerebral Hemorrh Failure, Dependence Vegetative State, Typ Muscle Wasting and A Disorder, Dysphagia, Neoplasm of Prostate The most recent adm	not provide laboratory ist have an agreement to from a laboratory that requirements of part 493 of is not met as evidenced iew, clinical record review, review, the facility staff tian ordered laboratory tests in the survey sample, the facility staff failed to re and a stool for occult is basis list indicated diagnoses, mited to Nontraumatic hage, Chronic Respiratory on Respirator, Persistent e 2 Diabetes Mellitus, Atrophy, Major Depressive Aphonia, and Malignant te. ission MDS (minimum data tessment reference date) of sident as being in a state.			F Tag 772 Lab Services no provided On-site Corrective Action Immediate corrective action was taken obtaining an occult blood obtained and results were negative. The sputum cul was not able to be obtained, the physi was notified and discontinued the order Identification To ensure that no other residents are affected, an audit of ordered labs for occult blood and sputum culture on the unit where resident #180 resides was conducted. Any area of non-complian for completing the lab was corrected b notifying the physician and resident representative. Any new orders by the physician will be followed. Systemic Change The licensed staff will complete re-education to ensure that they know proper steps if a lab is not able to be completed per physician order. The n	ture cian er. ce y e the	

Facility ID: VA0277

If continuation sheet Page 66 of 104

IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
IDENTIFICATION NOMBER.	A. BUILDING	<u> </u>	C
495019	B. WING		02/24/2022
		STREET ADDRESS, CITY, STATE, ZIP CODE	
HEALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302	
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE COMPLÉTIC
t #180's clinical record e practitioner) note dated stating in part "Patient has nined today because nurse brown emesis on 2/13/22 e/she) had another episode. d clear saliva in patient's utum culture and stool for esponding physician orders om stated "stool for occult 3:53 pm stated "Sputum C&S ity)". ident #180's clinical record on as unable to locate results for and stool for occult blood. On surveyor met with the ON (director of nursing) and s. yor had not received the f180's sputum culture and d results. or again reviewed the cord and the following noted in the resident's ab for sputum culture and sult pending". putum specimen sent to the ult pending". ame omitted) Laboratory dent stool for occult blood to the testing due to wrong kit. reorder the test".	F 77	shift supervisor or designee will reverse lab orders daily for the unit where # ensure that they were completed. A area of noncompliance will be immediately addressed to ensure the proper protocols are completed. A will be sent to the Unit Manager and Monitoring The ADON or designee will audit 20 all occult blood and sputum culture monthly. Any area of noncompliance be addressed by notifying the phys and resident representative. A quareport of noncompliance will be sub to the QAPI team for review, discuss and further recommendations. This continue for a minimum of 3 monther thereafter until 100% compliance is achieved; The QAPI Team will make formal recommendation when the	180 to Any nat report d DON. 0% of orders e will ician irterly pmitted ssion, will s and e a
	495019 HEALTHCARE CENTER TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESCIDENTIFYING INFORMATION) ge 66 t #180's clinical record e practitioner) note dated stating in part "Patient has nined today because nurse brown emesis on 2/13/22 a/she) had another episode. d clear saliva in patient's utum culture and stool for esponding physician orders on stated "stool for occult 3:53 pm stated "Sputum C&S ity)". dident #180's clinical record on as unable to locate results for and stool for occult blood. On surveyor met with the ON (director of nursing) and s. yor had not received the f180's sputum culture and d results. or again reviewed the cord and the following noted in the resident's ab for sputum culture and esult pending". putum specimen sent to the ult pending". ame omitted) Laboratory ident stool for occult blood to the testing due to wrong kit. reorder the test".	HEALTHCARE CENTER TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION) ID PREFIX TAG ge 66 F 77 t #180's clinical record e practitioner) note dated stating in part "Patient has nined today because nurse l brown emesis on 2/13/22 e/she) had another episode. d clear saliva in patient's utum culture and stool for responding physician orders om stated "stool for occult 3:53 pm stated "Sputum C&S ity)". F 77 ident #180's clinical record on as unable to locate results for and stool for occult blood. On surveyor met with the ON (director of nursing) and s. F yor had not received the #180's sputum culture and d results. F or again reviewed the cord and the following noted in the resident's F ab for sputum culture and esult pending". F putum specimen sent to the ult pending". F putum specimen sent to the ult pending". F ase on W an OP 02/17/22 at F	HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE TATEMENT OF DEFICIENCIES (CMUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTIONS HOU) CROSS-REFERENCED TO THE APPRC DEFICIENCY) ge 66 F 772 shift supervisor or designee will rev lab orders daily for the unit where 4. ensure that they were completed. A area of noncompliance will be immediately addressed to ensure th proper protocols are completed. A will be sent to the Unit Manager an utum culture and stool for supporting physician orders om stated "Stool for occult 3:53 pm stated "Sputum C&S ity)". Monitoring The ADON or designee will audit 2/ all occult blood and sputum culture monthily. Any area of noncompliance be addressed by notifying the phys and resident representative. A qua report of noncompliance will be sachieved; The QAPI team for review, discus and further recommendations. This continue for a minimum of 3 month thereafter until 100% compliance is achieved; The QAPI Team will mak formal recommendation when the monitoring can conclude based on compliance. or again reviewed the sord and the following noted in the resident's ab for sputum culture and sut pending". putum specimen sent to the alt pending". ame omitted) Laboratory dent stool for occult blood to the testing due to wrong kit. reorder the test". seen by a NP on 2/17/22 at

Facility ID: VA0277

If continuation sheet Page 67 of 104

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					FORM	APPROVED 0.0938-0391
STATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495019	B. WING				C 24/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 2729 KING ST		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE		
F 772	brownish sputum drai mouth, issue has bee provider, labs have be results which usually meantime, patient will for any bleeding as (h A progress note dated part "Writer unable to [sp] due to stool kit is evening shift and mar note dated 2/21/22 at stool for occult blood notified". A progress note dated "Lab called for resider according to result cu to specimen quality is notified assessment of culture repeat test not resident [sp] remain s Surveyor requested a policy entitled "Lab ar Clinical Protocol" whic physician will identify testing based on the r monitoring needs. 2. requisitions and arran laboratory, diagnostic testing source will rep facility". On 2/24/22 at 8:05 an administrator and DO concern of Resident #	ning from side of (his/her) n addressed by another een ordered. Awaiting takes couple of days. In the be continually monitored ue/she) has chronic anemia". d 2/18/22 5:19 pm stated in collect the stool for occult unavailable. Nurse on hager notified". A progress 12:41 pm states "Resident done, result negative, MD d 2/22/22 at 3:09 pm states in result for sputum culture, lture cancelled 2/17/22 due inadequate for culture. NP lone order to discontinue t needed at this time, table". nd received the facility nd Diagnostic Test Results - ch read in part: "1. The and order diagnostic and lab resident's diagnostic and The staff will process test ge for tests. 3. The radiology provider, or other out test results to the	F	772			

Facility ID: VA0277

If continuation sheet Page 68 of 104

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/03/2022 MAPPROVED D. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONST		(X3) DATE SURVEY COMPLETED		
		495019	B. WING			C 02/24/2022		
NAME OF PF	ROVIDER OR SUPPLIER	•	1	STREET	ADDRESS, CITY, STATE, ZIP CODE		-	
WOODBIN	E REHABILITATION & H	IEALTHCARE CENTER		2729 KIN ALEXAN	IG ST NDRIA, VA 22302			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 772	obtained and the orde 2/22/22. No further information presented to the surv	ras never successfully er was discontinued on n regarding this concern was rey team prior to the exit	F	772				
F 812 SS=D	conference on 2/24/2 Food Procurement,St CFR(s): 483.60(i)(1)(1) §483.60(i) Food safet The facility must -	tore/Prepare/Serve-Sanitary 2)	F٤	312			3/30/22	
	state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to co safe growing and foo (iii) This provision doe	ed satisfactory by federal, ies. ood items obtained directly subject to applicable State						
	serve food in accorda standards for food se This REQUIREMENT by: Based on observatio	is not met as evidenced n, staff interview the facility od in a safe and sanitary		Imm	rrective Action nediate corrective action was tal n both refrigerators inside and o			
	The findings include: During rounds on 2/2	4/2022, the surveyor		To e	ntification ensure that no other residents w cted, all nourishment refrigerate			

Event ID: URQT11

Facility ID: VA0277

If continuation sheet Page 69 of 104

		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVE 0. 0938-039
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495019	B. WING		02	C 2/24/2022
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	i •-	
				2729 KING ST		
WOODBIN	E REHABILITATION & H	IEALTHCARE CENTER		ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 812	on unit 1 North had d compartment handle substance on the free front of the refrigerato floor in front of the ref vanilla magic cup in t melted, then refrozen white substance in a the bottom of the free and debris on the floo no thermometer in the found a second therm compartment and mo temperature record s The nurse on the unit of the temperatures a The surveyor notified concern. The admini	rigerator in the nutrition room ebris in the refrigerator and there was a sticky ezer handle and down the or compartment and in the frigerator. On 2 north, a he freezer appears to have a (lying on its side with the stream around the lid and on ezer). There was also hair or of the freezer. There was e freezer, but the nurse nometer in the refrigerator oved it to the freezer. The heet said the unit was clean. t stated night shift take care and cleaning. the dietary manager of the strator and director of of the concern during a	F 81	 were inspected and if and any were inspected and if and any were inspection and outside. Systemic Change The nursing team will be re-educed how to wipe up after splattering Housekeeping will be re-educated process for inspecting and clear nourishment refrigerators. The Manager or designee will be ress for inspecting the nourishment refrigerators in the mediately corrected, and refrigerators weekly. Any area of non-compliance will be given to Administrator. The housekeeping supervisor will be required to instant and the immediately corrected, and a refrigerators weekly area of non-compliance will be given to Administrator. Monitoring The Assistant Administrator or distrator. Monitoring The Assistant Administrator or distrator will submit a Quar report of any area of non-compliance will submit a Quar report of any area of non-compliance mediately corrected. The Administrator will submit a Quar report of any area of non-compliance mediately corrected. The Administrator will submit a Quar report of any area of non-compliance mediately corrected. The Administrator will submit a Quar report of any area of non-compliance mediations. This will comminimum of 3 months and there 100% compliance is achieved; The Assistant comminimum of 3 months and there 	ediately cated on liquids. ed on the ning the Unit ponsible efrigerator ance will eport of the Asst. ng spect the y, any port of the Asst. esignee igerators ance will Asst. terly ance to ssion and titnue for a after until The QAPI	
F 825 SS=D	Provide/Obtain Speci	alized Rehab Services	F 82	Team will make a formal recomr when the monitoring can conclu on 100% compliance.		3/30/22

Facility ID: VA0277

If continuation sheet Page 70 of 104

		D HUMAN SERVICES MEDICAID SERVICES				INTED: 05/03/2022 FORM APPROVED IB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION) DATE SURVEY COMPLETED
		495019	B. WING			C 02/24/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP	CODE	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		729 KING ST ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETION DATE
F 825	Continued From page CFR(s): 483.65(a)(1)(F 825			
	not limited to physical pathology, occupation therapy, and rehabilita illness and intellectua lesser intensity as set	of services. ative services such as but therapy, speech-language hal therapy, respiratory ative services for mental I disability or services of a forth at §483.120(c), are ht's comprehensive plan of				
	§483.65(a)(2) In acco obtain the required se resource that is a pro- rehabilitative services participating in any fe programs pursuant to the Act.	e the required services; or rdance with §483.70(g), ervices from an outside vider of specialized and is not excluded from deral or state health care section 1128 and 1156 of				
	Based on resident int clinical record review, provide specialized re ordered by the physic the survey sample, Re For Resident #275, th	e facility staff failed to therapy as ordered by the		F Tag 825 D Obtain spect Corrective Action Immediate corrective action contacting the nurse prace resident #275 to notify that had not received the occu per the MD order. This was communicated directly wit with understanding. The seen by OT on February	on was taken by titioner for at the resident upational therapy as also th the resident resident was	, ,
		nosis list indicated uded, but not limited to Sclerosis, Acute and Chronic		Identification To ensure that no other re affected, an audit of all re		

Event ID: URQT11

Facility ID: VA0277

If continuation sheet Page 71 of 104

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/03/2022 M APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED C
		495019	B. WING				/24/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			29 KING ST LEXANDRIA, VA 22302		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 825	Status, Type 2 Diabed Failure, Severe Prote Dysphagia, Hypotens Ulcer. The most recent adm set) with an ARD (ass 2/04/22 assigned the interview for mental s out of 15 indicating th intact. Resident #275 extensive assistance totally dependent with toileting, personal hyg section O, Special Tre Programs, the residen day of OT (occupation minutes in the last 7 of minutes of OT in the p On 2/15/22 at 4:14 pr Resident #275 with th using a dry-erase boar resident if they had an responded they were A review of Resident revealed a current ph 1/28/22 stating "Occu (evaluation) and Treat dated 1/31/22 stating Skilled OT tx (therapy x 8 weeks for self car therapeutic activities,	Dependence on Respirator tes Mellitus, Epilepsy, Heart in-Calorie Malnutrition, ion, and Sacral Pressure ission MDS (minimum data sessment reference date) of resident a BIMS (brief tatus) summary score of 15 e resident was cognitively 5 was coded as requiring with dressing and being a bed mobility, transfers, giene, and bathing. In eatments, Procedures, and at was coded as receiving 1 hal therapy) for at least 15 days and 43 individual bast 7 days. m, surveyor spoke with he resident communicating ard. Surveyor asked the hy concerns and the resident not getting therapy. #275's clinical record ysician's order dated ipational Therapy Eval t as Indicated" and an order "OT clarification order: d) QD (every day) 3 x a week e management training, therapeutic exercises".	F	325	unit where resident #275 resides was conducted to ensure that physicians orders for occupational therapy are be followed. Any area of non-compliance was reported to the physician for instruction and to the administrator. T resident and resident representative would be notified. The therapist would receive 1:1 counseling regarding follow physicians orders. Systemic Change The rehab staff were re-educated regarding following physicians □ order and if unable to, the physician, the administrator and the resident representative would need to be contacted immediately. The Rehab Director will review with OT staff daily any resident that resides on the unit where resident #275 resided did not receive OT per physician order. The physician, the administrator and the resident or resident representative wo be contacted. Monitoring The URCM or designee will audit 20% residents receiving OT on the unit whe resident #275 resides to ensure that physicians orders for OT are being followed. Any area of non-compliance would be reported immediately to the physician and the administrator. The Rehab Director would be subject to counseling and re-education. The UR or dosignee will audit a represent of	he wing s if uld of ere	
	Resident #275's curre person-centered plan intervention dated 1/2	-			or designee will submit a report of non-compliance to the QAPI team quarterly for further discussion and		

Facility ID: VA0277

If continuation sheet Page 72 of 104

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/03/2022 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495019	B. WING _				C / 24/2022	
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
WOODBIN	NE REHABILITATION & H	IEALTHCARE CENTER			29 KING ST LEXANDRIA, VA 22302			
(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)	BE	(X5) COMPLETION DATE	
F 825	therapy)/OT evaluation orders". Surveyor was unable any treatment notes in record. On 2/16/22 at the administrator, ass DON (director of nurse review any OT docume #275. On 2/23/22 at 10:47 at nursing) provided sur resident's "OT Evaluated dated 1/31/22. "The Treatment" stated in Services: Skilled OT assess safety with act the need for adaptation develop and instruct and instruct on adapt and instruct on comp dynamic standing ball independence with A facilitate sitting tolerated increase functional and safety awareness in of quality of life by impro- return to prior level of Along with the "OT E Treatment", the admin OT Treatment Encour 2/18/22. On 2/24/22 at 9:01 at (occupational therapit treatment encounter	on and treatment as per MD to locate OT evaluation or in the resident's clinical at 4:00 pm, surveyor met with sistant administrator, and sing) and requested to mentation regarding Resident am, the DON (director of veyor with a copy of the ation & Plan of Treatment" OT Evaluation & Plan of part "Reason for Skilled services are warranted to daptive equipment, assess ons/assistive devices, in exercise program, develop ensatory strategies, facilitate lance, facilitate DLs (activities of daily living), nce and postural control, ctivity tolerance and increase order to enhance patient's oving ability to be able to f living".	F	325	recommendations. This will continue f minimum of 3 months and thereafter u 100% compliance is achieved; The Q. Team will make a formal recommenda when the monitoring can conclude ba on 100% compliance.	ıntil API ıtion		

Facility ID: VA0277

If continuation sheet Page 73 of 104

		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	
		495019	B. WING				_ 24/2022
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		•
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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 825	stated the resident did between 1/31/22 and were unsure of the re- supervisor makes the attempted to call their were unavailable. On 2/24/22 at 9:21 ar IDOR (Interim Director Manager) via phone v was not seen by OT k due to OT staff being IDOR stated the facili and one COTA (certifi assistant) and one O COVID-19 and anothe positive for COVID-19 time residents were s the biggest focus bein Skilled residents and skilled. IDOR further returning and they are future and a new OT stated Resident #275 times per week. On 2/24/22 at 10:26 a administrator of the ca from the IDOR. Admi contact the IDOR and On 2/24/22 at 1:20 pr to the surveyor and si to identify other reside been affected. Admi with a therapy clinical at 1:11 pm stating "Tr rehab) spoke with NF	d not have OT visits 2/18/22. OT #1 stated they ason and stated their treatment schedule, OT #1 supervisor, however, they n, surveyor spoke with	F	825	5		

If continuation sheet Page 74 of 104

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		495019	B. WING				_ 24/2022
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
	of care) starting on 1. understanding in the in questions". A second dated 2/24/22 at 1:15 stated in part, "This in resident via phone req frequency during this report understanding On 2/24/22 at 4:35 pr administrator, assista director of nursing and Resident #275 not red No further information presented to the survic conference on 2/24/22 Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Residen (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 th to do so. §483.70(i) Medical ref §483.70(i) 1 In accord	31.2022. NP reports matter and has no further therapy clinical update note pm was provided, note therim DOR spoke with garding the inability to meet POC. Resident able to via head nod". In, survey team met with the nt administrator, and d discussed the concern of ceiving OT as ordered. In regarding this issue was ey team prior to the exit 2. Identifiable Information 483.70(i)(1)-(5) Int-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		825			3/30/22

Facility ID: VA0277

If continuation sheet Page 75 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/03/2022 MAPPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495019	B. WING				C 24/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		2	2729 KING ST		
WOODDIN				4	ALEXANDRIA, VA 22302		
(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 (iv) Systematically org §483.70(i)(2) The faci 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 pur 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 res	e 75 ganized lity must keep confidential ned in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance activities, reporting of abuse, violence, health oversight administrative proceedings, ioses, organ donation urposes, or to coroners, ineral 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 int in State law; or ars after a resident reaches law.		842	DEFICIENCY)		

If continuation sheet Page 76 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/03/20 FORM APPROVI OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495019	B. WING		C 02/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • • • • • • • • • • • • • • • •	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		729 KING ST LEXANDRIA, VA 22302		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO	
F 842	Continued From page	e 76	F 842			
		/ preadmission screening				
	and resident review e					
	determinations condu					
		's, and other licensed				
	professional's progre					
		ogy and other diagnostic				
		equired under §483.50. is not met as evidenced				
	by:	is not met as evidenced				
	· ·	iew, clinical record review,		F Tag 842 Resident Records		
	and facility document	review, the facility staff				
		nplete and accurate clinical		Corrective Action		
		idents, Resident #279, #214,		Immediate corrective action was take	en for	
	#236, #260, #62, #92	, #143 and #180.		resident #279 by notifying the nurse		
	For Decident #270 th	a nurse prestitioner		practitioner who wrote the note. The		
	For Resident #279, the	lent expired in the ED		nurse practitioner immediately made addendum and clarified the error in t		
	(emergency departme	-		medical record.		
		nced and expired at the		For residents #214 and #236, immed	liate	
	nursing facility.	·		corrective action was taken by confir		
				that the local health department had	not	
		esident #236's clinical		received physical results from the		
		to include evidence of the		Maryland State Lab for these two		
		ry samples for a C. auris test resident #214's clinical		residents. Forms were then complet indicate that the labs for C. Auris and		
		to include laboratory results		CRE were drawn, and results record		
	for the C. auris test a	-		those forms with information given to		
				Woodbine from the City of Alexandria		
		cal documentation failed to		Health Department via email. These	;	
		ne collection of a laboratory		forms were then uploaded into the E	MR	
		ris test. Resident #260's		for residents #214 and #236.		
		n failed to include laboratory		For resident #260 immediate correct		
	results for the C. auri	S IESI.		action was taken by confirming that t local health department had not rece		
	Candida auris (C. aur	ris) is a fungus that is often		physical results from the Maryland S		
	multidrug-resistant			Lab. Forms were then completed to		
		/fungal/candida-auris/index.h		indicate that the lab for CRE was col		
	tml on 3/2/22). Carba			and result recorded on that form with		
		RE) are bacteria "that		information given to Woodbine from	th a	

Facility ID: VA0277

If continuation sheet Page 77 of 104

			()(0)	E OONOTRUCTION		B NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	, ,	DATE SURVEY COMPLETED
			A. BUILDING		-	С
		495019	B. WING			02/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	
WOODBIN	E REHABILITATION & H	IEALTHCARE CENTER		2729 KING ST		
				ALEXANDRIA, VA 223	302	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 842	Continued From page	e 77	F 84			
		ctions in healthcare settings			a Health Department via	
		treat because they do not			was then uploaded into	
	respond to commonly	/ used antibiotics."		the EMR of reside	ent #260.	
		/hai/organisms/cre/ on			the physician was	
	3/2/22).				new order was received	
	For Decident #62 the	e facility staff documented		to administer the PEG-tube.	levothyroxine via	
		Levothyroxine by mouth		-	the physician was	
		was being administered via			new order was received	
	PEG-tube.				famotidine and Keppra	
				via PEG-tube.		
		e facility staff documented			3, the physician was	
		Famotidine and Keppra by			new order was received	
	mouth when the med administered via PEG	0		to administer the PEG-tube.		
	For Decident #142 th	as facility staff desumanted), the physician was new order was received	
		ne facility staff documented Hydralazine by mouth when			Ferrous Sulfate via	
		eing administered via		PEG-tube.		
				Identification		
		ne facility staff documented			o other residents were	
		Ferrous Sulfate by mouth			t was completed on all	
		was being administered via			s in the last 30 days to	
	PEG-tube.				ormation was in the ny areas found in	
					the physician or his/her	
	The findings included	1:			contacted to make an	
				-	rect the information. All	
	1. This was a closed	record review.			d a lab drawn for C. Auris	
					Maryland State Lab	
	Resident #279's face				has been down, have a	
		primary osteoarthritis left havioral disturbance, and			o indicate that a lab was sults. Any area of	
	peripheral vascular di			non-compliance		
					e official results are sent	
	Section C (cognitive p	patterns) of Resident #279's			d State Lab to the City of	
	quarterly MDS (minim	num data set) assessment		Alexandria Health	n Department. All	
	with an ARD (assess	ment reference date) of		residents that rec	eive their medications	

Facility ID: VA0277

If continuation sheet Page 78 of 104

		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 05/03/20 RM APPROV IO. 0938-03
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495019	B. WING		0	C 2/24/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP		
				2729 KING ST		
WOODBIN		HEALTHCARE CENTER		ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 842	Continued From pag	ie 78	F 84	12		
	01/07/22 was coded	1/1/2 to indicate the resident		via PEG-tube will have the		
	-	ong and short term memory impaired in cognitive skills		route reviewed. Any medi indicates the wrong route,		
	for daily decision ma			will be contacted for an or		
	, <u></u>	5		medication delivered via P		
		ical record was reviewed on				
		ed the following progress				
	notes.			Systemic Change The Nurse Practitioner rec	vaived	
	01/24/22 Nurse Prac	titioner documented a		re-education on ensuring of		
		at read in part, "was found		information is placed in the		
		PR initiated and EMS		Director of Medical Record		
	calledpassed away	y in ED."		will audit all death summar		
	01/02/00 L DNI (licent	and practical purses) #1		proper information is in the		
		sed practical nurse) #1, illy pronounced expired at		areas of non-compliance v with the Medical Director to		
		per 911 staff member		Physician or designee to c	•	
		ed and gave order to release		information and provide ec		
	resident's remains to	pFuneral homeAt		The infection preventionist	and nursing	
		ains was released to		leadership will be educated		
	Funeral Home with f	amily at bedside."		paper form anytime a lab i		
	02/15/22 2·30 n m	the DON (director of nursing)		the Maryland State Labora computer system is working	•	
		alled and the resident expired		will indicate when the lab v	•	
	at the facility.			the results once received v		
				the City of Alexandria Hea		
	-	rovided the surveyor with a		from the Maryland State La	•	
	copy of their policy ti Documentation." Thi			Director of Clinical Record will audit the monthly PPS		
		the medical record will be		Admissions that the tests a		
	objectivecomplete			ensure that the forms are		
				uploaded. Any areas of no		
		on regarding this issue was		will be shared with the Infe		
	provided to the surve conference.	ey team prior to the exit		Preventionist and Director	0	
				Re-education and counsel licensed staff that drew the	-	
				completed.		
		liagnoses included, but were		All licensed staff received	re-education on	
		plood pressure, orthostatic		ensure to that physician or	ders are	

Facility ID: VA0277

If continuation sheet Page 79 of 104

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 05/03/20 RM APPROVE NO: 0938-03
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495019	B. WING _			0	C 2/24/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	E REHABILITATION & H	EALTHCARE CENTER			729 KING ST LEXANDRIA, VA 22302		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 842	 842 Continued From page 79 hypotension, neurogenic bladder, diabetes, and respiratory failure. Resident #214's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/24/21, was signed as completed on 12/29/21. Resident #214 was assessed as rarely 		F	342	received for medications via proper r Unit Manager or designee will review new orders for residents that have a PEG-tube to ensure that the proper r is indicated for medication route. Monitoring	/ all	
	or never able to make rarely or never able to Resident #214 was a impaired cognitive sk Resident was docum others for bed mobilit	e self understood and as			The Assistant Administrator or design will review 20% of all death summari per month to ensure that the correct information is in the summary. Any a of non-compliance will be corrected by notifying the physician for an addend the medical record. A quarterly repo non-compliance will be submitted by	es area by lum in rt of	
	policy titled "Charting document was not da - "All services provide toward the care plan resident's medical, ph psychosocial condition	ed to the resident, progress goals, or any changes in the			Assistant Administrator to the QAPI t for review and further discussion. The ADON or designee will audit 200 the PPS and Admission tests complet by the Maryland State Lab to ensure the form has been completed until th computer system is working. Any are non-compliance will be immediately	% of eted that e lab	
	record should facilitat the interdisciplinary te condition and response	te communication between eam regarding the resident's se to care." he medical record will be ated or speculative),			corrected and the Infection Preventic or designee will receive re-education the completion of the form. A quarte report of non-compliance will be sub- to the QAPI team to review for discus and recommendations. The ADON or designee will review 2	on rly mitted ssion	
	was having C. auris a completed on resider prevent the spread of of Resident #214's cli evidence the resident auris and/or CRE.	n an area of the facility that and CRE laboratory test hts as part of a plan to f these organisms. Review inical record failed to provide t had been tested for C.			the new orders for residents that use PEG-tube to ensure that the proper r is indicated in the physician order. A areas of non-compliance will be corre- by contacting the physician for an or- for the correct route. A quarterly rep non-compliance will be submitted to QAPI team for review, discussion, ar recommendations. This will continue	a oute ny ected der ort of the nd	

Event ID: URQT11

Facility ID: VA0277

If continuation sheet Page 80 of 104

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE S	0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPL	
					c	
		495019	B. WING	·····	02/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
WOODBIN	E REHABILITATION & H	EALTHCARE CENTER		2729 KING ST		
				ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 842	Continued From page	e 80	F 84	12		
1 012		ded a copy of a spreadsheet	1 04	minimum of 3 months and	thereafter until	
		en collection information and		100% compliance is achiev		
		on for facility residents.		Team will make a formal re		
	-	cimen collection information		when the monitoring can c	onclude based	
	and tests results wer			on 100% compliance.		
		preadsheet indicated the				
	· ·	for the C. auris and CRE obtained on 1/25/22 at 4:13				
		espectively. The spreadsheet				
		214 had negative results,				
	reported on 2/8/22, fo	or both test. The specimen				
		and tests results were not				
	documented as part or record.	of Resident #214's clinical				
	On 2/23/22 at 11:53 a	a.m., a local health				
	department employe	e (LHDE #1) was interviewed				
		#1 reported the laboratory				
		auris and CRE tests has had				
		resulted in them having to report the results of these				
		DE #1 reported the laboratory				
		ng communicated via email.				
		eir understanding was that				
	-	e going to document the				
		record via a "health note"				
	Indicating if the tests	were negative or positive.				
	On 2/23/22 at 4:12 p.	.m., the facility's				
		erviewed about the absence				
		C. auris and CRE specimen				
		sults in residents' medical				
		strator stated they could				
	-	lts, which were sent via a e local health department.				
		ported they would implement				
		ed that will be used to				
	document the test res					
	modical records Th	e Administrator reported a				

Facility ID: VA0277

If continuation sheet Page 81 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/03/2022 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		495019	B. WING				C 24/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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 842	provider order for the should be signed off, records, as completed collected. The failure of facility s #214's laboratory spe results, for C. auris ar a final time with the fa Director of Nursing, a on 2/24/22 at 4:39 p.r 3. Resident #236's dia not limited to: high bl bladder, diabetes, and Resident #236's minin assessment, with an a (ARD) of 1/25/22, was 1/31/22. Resident #2 sometimes able to ma usually able to unders #236's BIMS (Brief In Summary Score was 15; this indicated inta- Resident #236 was do assistance with bed n eating, toilet use, and The following informa policy titled "Charting document was not da - "All services provide toward the care plan g resident's medical, ph	C. auris and CRE test in residents' medical d when the specimens are staff to document Resident cimen collection and test nd CRE, was discussed for acility's Administrator, nd Assistant Administrator n. agnoses included, but were ood pressure, neurogenic d respiratory failure. mum data set (MDS) assessment reference date s signed as completed on 36 was assessed as ake self understood and as stand others. Resident terview for Mental Status) documented as a 15 out of ct or borderline cognition. bocumented as requiring nobility, transfers, dressing, personal hygiene. tion was found in a facility and Documentation" (this ted): d to the resident, progress goals, or any changes in the pysical, functional or n, shall be documented in	F	842			
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR L Continued From page provider order for the should be signed off, records, as completed collected. The failure of facility s #214's laboratory spe results, for C. auris ar a final time with the fa Director of Nursing, a on 2/24/22 at 4:39 p.r 3. Resident #236's dia not limited to: high bl bladder, diabetes, and Resident #236's minin assessment, with an a (ARD) of 1/25/22, was 1/31/22. Resident #2 sometimes able to ma usually able to unders #236's BIMS (Brief In Summary Score was 15; this indicated inta- Resident #236 was do assistance with bed n eating, toilet use, and The following informa policy titled "Charting document was not da - "All services provide toward the care plan g resident's medical, ph psychosocial conditio the resident's medical	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF	ix	ALEXANDRIA, VA 22302 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLE

Facility ID: VA0277

If continuation sheet Page 82 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/03/2022 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		495019	B. WING			/24/2022
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CC		
WOODBIN	NE REHABILITATION & H	IEALTHCARE CENTER		29 KING ST LEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 842	condition and respon - "Documentation in t objective (not opinion complete, and accura Resident #236 was lift that was having C. au completed on resider prevent the spread of of Resident #236's cl evidence the resident auris and/or CRE. On 2/23/22 at 10:37 a Nursing (DON) provide that included specime test results information Resident #236's spect and tests results were spreadsheet. The sp specimen collection f laboratory test were of p.m. and 4:12 p.m. re- indicated Resident #22 both tests, reported of collection information documented as part of record. On 2/23/22 at 11:53 a department employeed via telephone. LHDE that performs the C. a computer issues that change the way they laboratory tests. LHE test results were bein LHDE #1 reported the	se to care." he medical record will be nated or speculative), ate." ving in an area of the facility uris and CRE laboratory test its as part of a plan to if these organisms. Review inical record failed to provide t had been tested for C. a.m., the facility's Director of ded a copy of a spreadsheet en collection information and on for facility residents. cimen collection information e included on this readsheet indicated the or the C. auris and CRE obtained on 1/25/22 at 4:13 espectively. The spreadsheet 236 had negative results, for on 2/8/22. The specimen and tests results were not of Resident #236's clinical	F 842			

Facility ID: VA0277

If continuation sheet Page 83 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>			(X3) DATE COMF	SURVEY LETED
		495019	B. WING				C 24/2022
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	E REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					(X5) COMPLETION DATE	
F 842	 indicating if the tests of On 2/23/22 at 4:12 p. Administrator was interest of documentation of C collection and test rest records. The Administ provide the test result secure email from the The Administrator rep a form to be completed document the test rest medical records. The provider order for the should be signed off, records, as completed collected. The failure of facility s #236's laboratory speresults, for C. auris ar a final time with the fa Director of Nursing, a on 2/24/22 at 4:39 p.r 4. Resident #260's dinot limited to: high bl bladder, diabetes, kid failure. Resident #260's mininassessment, with an a (ARD) of 2/7/22, was 2/9/22. Resident #260 a persistent vegetative discernible conscious documented as being 	record via a "health note" were negative or positive. m., the facility's erviewed about the absence C. auris and CRE specimen sults in residents' medical strator stated they could is, which were sent via a e local health department. borted they would implement ed that will be used to sults in the residents' e Administrator reported a C. auris and CRE test in residents' medical d when the specimens are staff to document Resident cimen collection and test ad CRE, was discussed for acility's Administrator, nd Assistant Administrator m. iagnoses included, but were ood pressure, neurogenic ney disease, and respiratory mum data set (MDS) assessment reference date signed as completed on 0 was assessed as being in e state and/or having no ness. Resident #260 was i dependent on others for	F	842	2		
		dependent on others for s, dressing, eating, toilet					

Facility ID: VA0277

If continuation sheet Page 84 of 104

	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE		(X3) DATE	SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		495019	2729 KING ST ALEXANDRIA, VA 22302 ID PROVIDER'S PLAN OF O PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO T				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBII	NE REHABILITATION & H	EALTHCARE CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 842	use, personal hygiene The following informa policy titled "Charting document was not da - "All services provide toward the care plan resident's medical, ph psychosocial conditio the resident's medica record should facilitat the interdisciplinary te condition and respons - "Documentation in th objective (not opinion complete, and accura Resident #260 was lin that was having C. au completed on residen prevent the spread of of Resident #260's cli evidence the resident auris. On 2/23/22 at 10:37 a Nursing (DON) provid which included specir and test results inform Resident #260's C. au information and test re spreadsheet. The sp auris specimen was c spreadsheet indicated test had been reporte The specimen collect	e, and bathing. tion was found in a facility and Documentation" (this ted): do the resident, progress goals, or any changes in the hysical, functional or n, shall be documented in I record. The medical e communication between eam regarding the resident's se to care." he medical record will be ated or speculative), ite." ving in an area of the facility tris laboratory tests its as part of a plan to these organisms. Review nical record failed to provide thad been tested for C. a.m., the facility's Director of led a copy of a spreadsheet, men collection information nation for facility residents. uris specimen collection esults were included on this readsheet indicated the C. obtained on 12/14/21. The d Resident #260 C. auris ed as positive on 12/22/22. ion information and tests imented as part of Resident	F	342			

If continuation sheet Page 85 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 05/03/2022 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		495019	B. WING			C 2/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 842	On 2/23/22 at 11:53 a department employee via telephone. LHDE that performs the C. a computer issues that change the way they #1 reported the labora communicated via em understanding was th members were going the clinical record via the tests were negativ On 2/23/22 at 4:12 p. Administrator was inte of documentation of th collection and test rese records. The Adminis provide the test result secure email from the The Administrator reporter auris test should be s residents' medical reco are collected. The failure of facility s #260's laboratory spe results, for C. auris, w with the facility's Adm Nursing, and Assistar at 4:39 p.m. 5. Resident #62's dia diagnoses, which incl	a.m., a local health a (LHDE #1) was interviewed #1 reported the laboratory auris and CRE tests has had resulted in them having to reported the results. LHDE atory test results were being hail. LHDE #1 reported their at the facility's staff to document the results in a "health note" indicating if ve or positive. m., the facility's erviewed about the absence he C. auris specimen sults in residents' medical strator stated they could as, which were sent via a e local health department. orted they would implement ted that will document the dents' medical records. The d a provider order for the C. igned off as completed, in cords, when the specimens staff to document Resident cimen collection and test vas discussed for a final time inistrator, Director of at Administrator on 2/24/22 signosis list indicated uded, but not limited to Failure, Type 2 Diabetes	F 842			

Facility ID: VA0277

If continuation sheet Page 86 of 104

DEPARTMENT OF HEALTH A				F	ORM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	· · ·	(X3) DATE SURVEY COMPLETED	
	495019	B. WING _			C 02/24/2022	
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODBINE REHABILITATION &	HEALTHCARE CENTER		2729 KING ST			
			ALEXANDRIA, VA 22302			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 842 Continued From pa	ge 86	F	342			
Nutritional Deficient Orthostatic Hypoter	ersistent Vegetative State, cy, Essential Hypertension, sion, Post Traumatic ndence on Respirator.					
The most recent quiset) with an ARD (a 11/21/21 coded the persistent vegetative coded as being total mobility, transfers, of personal hygiene, a coded for the present they received 51% of 501 cc/day or more Resident #62's curre person-centered platering "Resider (related to) NPO statering A review of Resider the resident was vere persistent vegetative tube feeding, and he for an NPO (nothing Surveyor reviewed physician's orders at dated 10/05/21 for 11 137 mcg 1 tablet by thyroid. Resident # (medication administ Levothyroxine was by mouth despite the On 2/23/22 at 11:322 (licensed practical r	arterly MDS (minimum data ssessment reference date) of resident as being in a e state. Resident #62 was lly dependent on staff for bed lressing, eating, toileting, nd bathing. The resident was noce of a feeding tube in which or more of total calories and average fluid intake. ent comprehensive and for a feeding tube feeding r/t tus". t #62 clinical record indicated ntilator dependent, in a e state, receives nutrition via as a current physician's order					

Facility ID: VA0277

If continuation sheet Page 87 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495019	B. WING				C 24/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST		
					ALEXANDRIA, VA 22302		
(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	987	F:	842	2		
	(medications).						
	administrator and DO informed them of Res	n, surveyor met with the N (director of nursing) and ident #62 having a current ∟evothyroxine to be given by					
	physician's order date Resident #62 stating 137 mcg to be admini also provided a nursir 2/24/22 1:05 pm statin	n, DON provided a copy of a ed 2/24/22 9:00 am for Levothyroxine Sodium tablet istered via PEG-tube. DON ng progress note dated ng in part "Clarification: ted) made aware from PO to G-tube".					
	policy entitled "Admin read in part "10. The medication checks the verify the right resider dosage, right time and administration before Surveyor also reviewe "Charting and Docum	entation" which read in part the medical record will be ated or speculative),					
	presented to the surve conference on 2/24/2						
	Acute Respiratory Fa Respirator Status, Ty	uded, but not limited to					

Facility ID: VA0277

If continuation sheet Page 88 of 104

	-	D 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	
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG _			C
		495019	B. WING _			02/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			729 KING ST ILEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 842	Aphonia.		F٤	342			
	set) with an ARD (ass 12/16/21 coded the re- impaired in cognitive a making with short-terr problems. The reside presence of a feeding	tube in which they received calories and 501 cc/day or					
	orders revealed a cur for a NPO (nothing by current physician order for the medications Fa administered by mout were ordered to be giv resident's February 20 administration record) and Keppra were sign	#92's current physician's rent order dated 12/17/21 r mouth) diet. The resident's ers included active orders amotidine and Keppra to be h, all other oral medications ven via PEG-tube. The 022 MAR (medication) indicated the Famotidine hed as being administered resident's NPO status.					
	(licensed practical nur #92 does not take any (medications). On 2/24/22 at 8:05 an administrator and DO	m, surveyor spoke with LPN rse) #2 who stated Resident y PO (by mouth) meds n, surveyor met with the N (director of nursing) and ident #92 having current					
	physician's orders for be given by mouth. Surveyor requested a policy entitled "Admin read in part "10. The	Famotidine and Keppra to nd received the facility istering Medications" which individual administering the e label THREE (3) times to					

Facility ID: VA0277

If continuation sheet Page 89 of 104

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/03/2022 MAPPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				LETED
		495019	B. WING				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODBU				:	2729 KING ST		
WOODBI	NE REHABILITATION & H	EALINCARE CENTER			ALEXANDRIA, VA 22302		
(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 842	verify the right resider dosage, right time and administration before Surveyor also reviewe "Charting and Docum "3. Documentation in objective (not opinion complete, and accura No further information presented to the surve conference on 2/24/22 7. Resident #143's di diagnoses, which incl Hemiplegia and Hemi Infarction, Cerebral E Respiratory Failure, T Chronic Kidney Disea Hypertension, Chronic Heart Failure, and De The most recent quar set) with an ARD (ass 12/31/21 coded the re- impaired in cognitive s making. Resident #14 totally dependent on s dressing, eating, toile bathing. The residen presence of a feeding 51% or more of total of more average fluid int A review of Resident s orders revealed a cur a NPO (nothing by mo-	nt, right medication, right d right method (route) of giving the medication". ed the facility policy entation" which read in part the medical record will be ated or speculative), te". aregarding this concern was ey team prior to the exit 2. agnosis list indicated uded, but not limited to paresis following Cerebral dema, Dysphagia, Acute type 2 Diabetes Mellitus, se Stage 3, Essential c Diastolic (Congestive) pendence on Respirator. terly MDS (minimum data sessment reference date) of esident as being severely skills for daily decision 43 was coded as being staff for bed mobility, t use, personal hygiene, and it was coded for the tube in which they received calories and 501 cc/day or	F	842			

Facility ID: VA0277

If continuation sheet Page 90 of 104

CENTERS FOR MEDICARE & MEDICAID SERVICES	(FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	CTION	(X3) DATE SURVEY COMPLETED
495019 B. WING		C 02/24/2022
	RESS, CITY, STATE, ZIP CODE	
WOODBINE REHABILITATION & HEALTHCARE CENTER ALEXANDR	T RIA, VA 22302	
	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 842 Continued From page 90 F 842 be administered by mouth, all other oral medications were ordered to be given via PEG-tube. The resident's February 2022 MAR (medication administration record) indicated the Hydralazine was signed as being administered by mouth despite the resident's NPO status. On 2/23/22 at 11:32 am, surveyor spoke with LPN (licensed practical nurse) #2 who stated Resident #143 does not take any PO (by mouth) meds (medications). On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and informed them of Resident #143 having a current physician's order for Hydralazine to be given by mouth. On 2/24/22 at 2:55 pm, the DON provided surveyor with a physician's order dated 2/24/22 8:56 am for Resident #143 for Hydralazine to be administered via G-tube. Surveyor requested and received the facility policy entitled "Administering Medications" which read in part "10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication." Surveyor also reviewed the facility policy "Charting and Documentation" which read in part "3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate". No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.		

If continuation sheet Page 91 of 104

-					FORM	APPROVED
F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
	495019	B. WING _				C 24/2022
ROVIDER OR SUPPLIER						
E REHABILITATION & H	EALTHCARE CENTER					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	x			(X5) COMPLETION DATE
Continued From page	91	F٤	342			
diagnoses, which incl Nontraumatic Intracer Respiratory Failure, D Persistent Vegetative Mellitus, Muscle Wash Depressive Disorder, Malignant Neoplasm of The most recent adm set) with an ARD (ass 1/20/22 coded the resp persistent vegetative is coded for the presence they received 51% or 501 cc/day or more ar A review of Resident is indicated the resident is indicated the resident is indicated the resident is indicated the resident is a persistent vegeta via tube feeding, and order dated 2/08/22 for mouth) diet. Resident #180's current person-centered plan area stating "Residen (related to) Dysphagia Resident #180's current included an active or medication Ferrous S mouth, all other oral m be given via PEG-tub 2022 MAR (medication	uded, not limited to rebral Hemorrhage, Chronic Dependence on Respirator, State, Type 2 Diabetes ting and Atrophy, Major Dysphagia, Aphonia, and of Prostate. ission MDS (minimum data tessment reference date) of sident as being in a state. The resident was the of a feeding tube in which more of total calories and verage fluid intake. #180 clinical record was ventilator dependent, tive state, receives nutrition has a current physician's or an NPO (nothing by ent comprehensive of care included a focus t requires tube feeding r/t a, Swallowing problem". ent physician's orders ler dated 1/26/22 for the ulfate to be administered by nedications were ordered to e. The resident's February in administration record)					
	S FOR MEDICARE & I DE DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER IE REHABILITATION & H SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From page 8. Resident #180 dia diagnoses, which incl Nontraumatic Intracer Respiratory Failure, D Persistent Vegetative Mellitus, Muscle Wast Depressive Disorder, Malignant Neoplasm of The most recent adm set) with an ARD (ass 1/20/22 coded the respiratory Failure, D persistent vegetative coded for the presence they received 51% or 501 cc/day or more ar A review of Resident are indicated the resident are included an active or medication Ferrous S mouth, all other or and be given via PEG-tub 2022 MAR (medicatio indicated the Ferrous being administered by	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION & HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 91 8. Resident #180 diagnosis list indicated diagnoses, which included, not limited to Nontraumatic Intracerebral Hemorrhage, Chronic Respiratory Failure, Dependence on Respirator, Persistent Vegetative State, Type 2 Diabetes Mellitus, Muscle Wasting and Atrophy, Major Depressive Disorder, Dysphagia, Aphonia, and Malignant Neoplasm of Prostate. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 1/20/22 coded the resident as being in a persistent vegetative state. The resident was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc/day or more average fluid intake. A review of Resident #180 clinical record indicated the resident was ventilator dependent, in a persistent vegetative state, receives nutrition via tube feeding, and has a current physician's order dated 2/08/22 for an NPO (nothing by	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 495019 B. WING_ ROVIDER OR SUPPLIER 495019 B. WING_ RERHABILITATION & HEALTHCARE CENTER IDENTIFICATION NUMBER: ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 91 F & 8. Resident #180 diagnosis list indicated diagnoses, which included, not limited to Nontraumatic Intracerebral Hemorrhage, Chronic Respiratory Failure, Dependence on Respirator, Persistent Vegetative State, Type 2 Diabetes Mellitus, Muscle Wasting and Atrophy, Major Depressive Disorder, Dysphagia, Aphonia, and Malignant Neoplasm of Prostate. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 1/20/22 coded the resident as being in a persistent vegetative state. The resident was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc/day or more average fluid intake. A review of Resident #180 clinical record indicated the resident was ventilator dependent, in a persistent vegetative state, receives nutrition via tube feeding, and has a current physician's order dated 2/08/22 for an NPO (nothing by mouth) diet. Resident #180's current comprehensive person-centered plan of care included a focus area stating "Resident requires tube feeding r/t (related to) Dysphagia, Swallowing problem". Resident #180's current physician's orders included an a	S FOR MEDICARE & MEDICAID SERVICES	S FOR MEDICARE & MEDICAID SERVICES Difference (x1) PROVIDENSUPPLIERCLIA LIDENTIFICATION NUMBER (x2) MULTIFICE CONSTRUCTION A BUILDING A95019 B. WING CORRECTION 495019 B. WING CORRECTION STREETADORESS, CITY, STATE, ZP CODE Z228 KING ST ALEXANDRIA, VA 22302 STREETADORESS, CITY, STATE, ZP CODE EREHABILITATION & HEALTHCARE CENTER STREETADORESS, CITY, STATE, ZP CODE BLOWNERY STATEMENT OF DEPRIENCIES (EACH DEPRICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH ORRECTIVE ATONO HOUSE DEPRIPTION REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 91 F 842 8. Resident #180 diagnosis list indicated diagnoses, which included, not limited to Nontraumatic Intracerebral Hemorrhage, Chronic Respiratory Failure, Dependence on Respirator, Persistent Vegetative state, Type 2 Diabetes Mellitus, Muscle Wasting and Arophy, Major Depressive Disorder, Dysphagia, Aphonia, and Malignant Neoplasm of Prostate. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 1/20/22 coded the resident as being in a persistent Vegetative state, receives mutrition via tube feeding, and has a current physician's order dated 2/08/22 for an NPO (nothing by mouth, diel. Resident #180's current comprehensive person-centered plan of care included a focus area stating "Resident regident's Ethe Berding r/t (related to) Dysphagia, Swallowing problem". Resident #180's current ph	MENT OF HEALTH AND HUMAN SERVICES FORMED FORMEDICARE & MEDICALD SERVICES OMB NC CORRECTION (X1) PROVIDER CONTRUCTION A BULDING (X2) PROVIDER CONTRUCTION A BULDING (X2) PROVIDER CONTRUCTION A BULDING (X2) MULTIPLE CONTRUCTION (X2) MULTIPLE CONTR

Facility ID: VA0277

If continuation sheet Page 92 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED C
		495019	B. WING			
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 842	Continued From page	92	F 84	42		
	(licensed practical nu	im, surveyor spoke with LPN rse) #2 who stated Resident ny PO (by mouth) meds				
	administrator and DO informed them of Res	n, surveyor met with the N (director of nursing) and ident #180 having a current Ferrous Sulfate to be given				
	policy entitled "Admin read in part "10. The medication checks the verify the right residen dosage, right time and administration before Surveyor also reviewe "Charting and Docum	entation" which read in part the medical record will be ated or speculative),				
F 880 SS=E	presented to the surv conference on 2/24/2 Infection Prevention &	& Control	F 8	80		3/30/22
		blish and maintain an nd control program safe, sanitary and lent and to help prevent the lismission of communicable				

Event ID: URQT11

Facility ID: VA0277

If continuation sheet Page 93 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		495019	B. WING				C 24/2022
NAME OF PF	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		-
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER			2729 KING ST ALEXANDRIA, VA 22302		
(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 880	Continued From page	93	F	880	0		
	§483.80(a) Infection p program. The facility must esta and control program (a minimum, the follow §483.80(a)(1) A syster reporting, investigatin and communicable di staff, volunteers, visite providing services un arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility (ii) When and to whor communicable disease reported; (iii) Standard and trart to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura	brevention and control blish an infection prevention IPCP) that must include, at ving elements: an for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards; standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other can spread to other se or infections should be usmission-based precautions ent spread of infections; blation should be used for a t not limited to:					
	involved, and (B) A requirement that least restrictive possil circumstances. (v) The circumstances	t the isolation should be the ole for the resident under the s under which the facility ses with a communicable					

Facility ID: VA0277

If continuation sheet Page 94 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/03/2022 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495019	B. WING		C 02/24/2022
NAME OF PI	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE	
WOODBIN	IE REHABILITATION & H	EALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 880	contact will transmit th (vi)The hand hygiene by staff involved in din §483.80(a)(4) A syste identified under the factor corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update their This REQUIREMENT by: Based on observation document review, and complaint investigation implement infection c program processes, in the risks of transmiss other infectious organ residents (Resident # Resident #226. The factility CO processes for a readr yet received the COV For Resident #135, R	kin lesions from direct a or their food, if direct he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. le, store, process, and to prevent the spread of view. ct an annual review of its r program, as necessary. ' is not met as evidenced ns, interviews, facility d in the course of a on, the facility staff failed to ontrol and prevention ncluding actions to decrease ion of COVID-19 and/or hisms, for three (3) of 40 135, Resident #162, and facility staff failed to VID-19 quarantine nitted resident who had not ID-19 booster. esident #162, and Resident	F 880	F Tag 880 Infection Control and Prevention Corrective Action Immediate corrective action was take re-education for staff member #21 or requirement for screening when enter the facility. Immediate corrective action was take post the droplet precaution sign on the resident #135 door and receive order from the MD for droplet and contact precautions. Staff member #24 receive re-education regarding the requirement proper PPE for a room with both drop and contact precautions.	n the ring en to ne rs ved ent of olet
	#226, the facility staff	failed to ensure proper		Immediate corrective action was take	en by

Facility ID: VA0277

If continuation sheet Page 95 of 104

HUMAN SERVICES				FORM	D: 05/03/2022 APPROVED D: 0938-0391
(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
495019	B. WING _				C 24/2022
		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ALTHCARE CENTER					
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
 25 append (PPE) was worn the residents' rooms, assion-based precautions #21 failed to consistently reenings prior to starting a "Daily Timecards" bd of 12/26/21 to 2/5/2022 25 days (12/26/21; 10/22; 1/23/21; 1/4/22; 1/9/22; 1/11/22; 1/12/22; 22; 1/26/22; 1/27/22; 22; 1/26/22; 22; 1/26/22; 22; 22; 1/26/22; 22; 22; 1/26/22; 22; 22; 1/26/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 1/27/22; 22; 22; 22; 2/2; 2/2; 2/2; 2/2;	F 8	380	door of resident #162. Immediate corrective action was taken resident #226 by providing re-educated for the family of resident regarding pro- PPE and the reasoning for it. Identification To ensure that no other residents were affected, an audit of screening kiosk at the daily schedule was completed to ensure compliance. An audit of all residents that came from the hospital within the last 14 days were reviewed ensure that all residents that were not to date with Covid Vaccines were in proper observation. An audit of all Co Precaution signs was completed to ensure proper signage was on each of that required droplet or contact precautions. Families with loved ones contact isolation were re-educated on proper use of PPE while visiting. Systemic Change All staff members are completing competencies on DONNING and DOFFING of PPE for isolation and Ha Hygiene. All staff will be re-educated ensure that they complete screening at the entrance of the facility prior to start their shift. All families that have loved ones in Contact Pre-cautions will be re-educated to wear the proper PPE. infection preventionist or designee will make rounds daily and conduct observations daily on: Signage for Co	n for oper e and to t up ovid loor s in the and to at ting I The I I The I	
	EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495019 ALTHCARE CENTER EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL DENTIFYING INFORMATION) 45 ipment (PPE) was worn the residents' rooms, asion-based precautions 421 failed to consistently reenings prior to starting 421 failed to consistently 12/26/21; 12/31/21; 1/4/22; 12/26/22; 1/11/22; 1/12/22; 22; 1/18/22; 1/21/22; 22; 1/18/22; 1/21/22; 22; 1/26/22; 1/27/22; 22; 1/26/22; 1/27/22; 22; 1/26/22; 1/27/22; 22; 1/26/22; 1/27/22; 22; 1/26/22; 1/27/22; 23, 1/26/22. ., the Director of Nursing 1 had not consistently mployee COVID-19 ng work. ., Staff Member (SM) #21 een completing the ior to starting work ters were providing a to low; SM #21 reported a an incorrect temperature. on was found in a facility	EDICAID SERVICES (1) PROVIDER/SUPPLIEN/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 495019 B. WING	EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE: A BUILDING	EDICAID SERVICES (1) PROVIDERISUPPLIENCLIA IDENTIFICATION NUMBER: (22) MULTIPLE CONSTRUCTION A BUILDING 495019 B. WING ALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 2729 KING ST ALEXANDRIA, VA 22302 2239 KING ST ALEXANDRIA, VA 22302 INST BE PRECEDED BY FULL 2:DENTIFYING INFORMATION) p PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE) TO THE APPROPE DEFICIENCY) 55 F 880 placing a contact precaution sign on t door of resident #162. 15 F 880 ipment (PPE) was worn he residents' rooms, sision-based precautions F 880 "Daily Timecards" Identification To ensure that no other residents wer resident #226 by providing re-educati for the family of resident regarding pre PPE and the reasoning for it. *21 failed to consistently reenings prior to starting Identification To ensure that no other residents wer affected, an audit of screening kiosk a the daily schedule was completed to ensure that all residents that were no proper observation. An audit of all CO Precaution signs was completed to ensure proper signage was on each of that required droplet or contact precautions. Families with loved ones contact isolation were re-educated on that required droplet or contact precautions. Families with loved one ensure proper signage was on each of that required droplet or contact precaution signs was completed to ensure that all families that have loved the shift. All families that have loved ones in Contact Pre-cautions will be encomprecision DONI	EDICAID SERVICES OMB NO. 11) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (22) MULTIPLE CONSTRUCTION A BUILDING (23) DATE CONSTRUCTION A BUILDING 495019 b. WING (22) ALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE Z728 KING ST ALEXANDRIA, VA 22302 (22) EMENT OF DEFICIENCIES UBENT OF DEFICIENCIES IDENTIFING INFORMATION) D PREFIX TAS PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 55 D PREFIX TAS PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 56 PREFIX TAS F 880 10 PREFIX TAS Immediate corrective action was taken for resident #226 by providing proper PPE and the reasoning for it. 1201y Timecards* Identification To ensure that no other resident swere affected, an audit of screening kiosk and the daily schedule was completed to ensure compliance. An audit of all resident #122(12/2/2/11/2/2); 21/11/22; 11/1/22; 21/11/22; 11/1/22; 21/11/22; 11/1/22; 21/11/22; 11/2/22; 21/11/22; 11/22; 21/11/22; 11/2/22; 21/1

Facility ID: VA0277

If continuation sheet Page 96 of 104

TATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
	CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING	C	
		495019	B. WING	02/24/2022	
NAME OF F	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
WOODBI	NE REHABILITATION & H	HEALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302	
(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 880	Continued From page	e 96	F 880		
	 "Staff, visitors, and for COVID-19 in acco VDH, CMS, and CDO "HCP (healthcare p conducted at the beg "HCP must be screet symptoms of COVID- than or equal to) 100 cough, shortness of the chills, and new onset Prolonged close could COVID-19 infection in The failure of SM #22 COVID-19 screening discussed with the fator of Nursing, and Assis 2/24/22 at 4:39 p.m. Resident #135's of not limited to: anemitianxiety, depression, failure. Resident #135's minitiansessment, with an (ARD) of 12/29/21, wt 1/5/22. Resident #135's make self understood others. Resident #135's BIMS (Brief Interview Summary Score of a intact or borderline con assessed as requirint 	residents will be screening ordance with guidance from C." ersonnel) screening must be ginning of every shift." ened for: - Signs and -19 including: fever (greater 0 (degrees Fahrenheit), breath, sore throat, myalgia, t of loss of smell or taste; and ntact with someone with n the 14 days prior" 1 to consistently complete prior to starting work was ucility's Administrator, Director stant Administrator on diagnoses included, but were a, high blood pressure, lung disease, and respiratory imum data set (MDS) assessment reference date was signed as completed on 35 was assessed as able to d and as able to understand 35 was assessed as having a <i>v</i> for Mental Status) 15 out of 15; this indicated ognition. Resident #135 was g assistance with bed ating, dressing, toilet use,		signs are correct, Donning and Do PPE of staff going into and out of r Hand-hygiene of staff and ensuring families visiting are wearing the pr PPE. Any areas of noncompliance corrected immediately, and the stat member or family member will be re-educated. Monitoring The staffing coordinator or designe review 20% the staffing schedule a screening kiosk to ensure that the that worked completed screening in the start of their shift. Any areas of non-compliance will be reported immediately to the ADON and Infe preventionist for re-education and counseling. The ADON or designe conduct 30 observations per day the could include for Donning and Doff hand-hygiene, family visitation in r with PPE or Signage of Contact or Precautions to ensure that is being conducted properly. Any area of non-compliance will be immediate corrected and reported to the DON Infection Preventionist. The ADON send a monthly report of non-compt to the QAPI team for review, discu- and recommendations. This will co for a minimum of 3 months and the until 100% compliance is achieved QAPI Team will make a formal recommendation when the monito conclude based on 100% compliance	room, g that oper e will be aff ee will and the staff prior to f ection ee will hat fing, ooms Droplet g ly N and N will pliance ission, pontinue ereafter d; The ring can
	COVID-19 infection in The failure of SM #22 COVID-19 screening discussed with the fa of Nursing, and Assis 2/24/22 at 4:39 p.m. 2. Resident #135's di not limited to: anemi anxiety, depression, failure. Resident #135's mini assessment, with an (ARD) of 12/29/21, w 1/5/22. Resident #13 make self understood others. Resident #13 BIMS (Brief Interview Summary Score of a intact or borderline of assessed as requirin mobility, transfers, ea	n the 14 days prior" 1 to consistently complete prior to starting work was icility's Administrator, Director stant Administrator on diagnoses included, but were a, high blood pressure, lung disease, and respiratory imum data set (MDS) assessment reference date vas signed as completed on 35 was assessed as able to d and as able to understand 35 was assessed as having a v for Mental Status) 15 out of 15; this indicated ognition. Resident #135 was g assistance with bed ating, dressing, toilet use,		review 20% the staffing schedule a screening kiosk to ensure that the that worked completed screening if the start of their shift. Any areas of non-compliance will be reported immediately to the ADON and Infe preventionist for re-education and counseling. The ADON or designe conduct 30 observations per day t could include for Donning and Dof hand-hygiene, family visitation in r with PPE or Signage of Contact or Precautions to ensure that is being conducted properly. Any area of non-compliance will be immediated corrected and reported to the DON Infection Preventionist. The ADON send a monthly report of non-comp to the QAPI team for review, discu and recommendations. This will co for a minimum of 3 months and the until 100% compliance is achieved QAPI Team will make a formal recommendation when the monito	and the staff prior to f ection ee will hat fing, ooms Droplet J V and N will pliance ission, ontinue ereafter d; The ring can

Facility ID: VA0277

If continuation sheet Page 97 of 104

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/03/2022 // APPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495019	B. WING				C 24/2022	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
				2	2729 KING ST			
WOODBINE REHABILITATION & HEALTHCARE CENTER				ALEXANDRIA, VA 22302				
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE	
F 880	Admissions and Resid Facility" (dated April 2 February 2022): "Resident with all recommendoses and are new active who left the facility for placed in quarantine." provide details for plating quarantine. The facility's Administ Nursing (DON) were it 8:40 a.m. The failure New Admissions and Facility" document to placing a resident on The Administrator rep quarantine due to pot would be placed on D During an interview of DON reported Reside required quarantine a facility due to the resi- COVID-19 vaccine boo Resident #135's clinic for "CONTACT AND I dated six (6) days after re-admitted to the fac- after a hospital stay.) On 2/16/22 at 1:10 p. (a unit manager) was room had a sign poster not Droplet Isolation. Isolation sign was poster was only on observat	dents Who Leave the 2, 2021 and last updated sidents who are not up to ended COVID-19 vaccine dmissions and residents more than 24 hours will be ' This document did not cing a resident in rator and Director of interviewed on 2/24/22 at of the "CDC Guidance - Residents Who Leave the detail the process for quarantine was discussed. orted a resident placed on ential COVID-19 exposure proplet Isolation precautions. n 2/24/22 at 10:21 a.m., the ent #135 would have fter their re-admission to the dent not having received the poster. cal record included an order DROPLET ISOLATION"	F	880				

Facility ID: VA0277

If continuation sheet Page 98 of 104

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495019	B. WING			C 02/24/2022		
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODBIN	WOODBINE REHABILITATION & HEALTHCARE CENTER				2729 KING ST ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 880	time of this observation On 2/16/22 at 1:26 p. practical nurse) was of Isolation sign on the of #135's room. On 2/16/22 at 2:30 p. Nursing and Infection Resident #135's room posted for both Conta- isolation from the time readmission after the On 2/17/22 at 8:55 a. nurse aide) was obse #135's room without of SM #24 placed clean #135's room and exite 9:00 a.m., SM #22 (a interviewed about SM #135's room to drop-of reported SM #24 shot and gloves prior to em The facility's Administ and Assistant Administ team on 2/24/22 at 4: facility staff to ensure for Droplet Isolation p when re-admitted to t stay was discussed. member entering Res donning a gown or glo	DPLET ISOLATION" at the on. m., SM #23 (a licensed observed posting a Droplet door leading into Resident door leading into Resident m., the facility's Director of Preventionist reported that a should have had signage to Isolation and Droplet e of the resident's hospital stay. m., SM #24 (a certified rved to enter Resident donning a gown and gloves. linen on a table in Resident donning a gown and gloves. linen on a table in Resident ed the room. On 2/17/22 at unit manager) was 1 #24 entering Resident off clean linen; SM #22 uld have donned a gown tering the room. rrator, Director of Nursing, strator met with the survey 39 p.m. The failure of the Resident #135 had orders recautions for quarantine he facility after a hospital The observations of a staff to observatio	F	880				
	3. Resident #162's ad diagnoses to include Parkinson's disease,	but not limited to,						

If continuation sheet Page 99 of 104

	OMB NO. 09	PROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A RUM DIVIC	(X3) DATE SUR COMPLETE	VEY	
AND FEAR OF CORRECTION ADDITION NOWBER. A. BUILDING	C	.0	
495019 B. WING	02/24/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODBINE REHABILITATION & HEALTHCARE CENTER 2729 KING ST ALEXANDRIA, VA 22302			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION STATEMENT OF DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE CO	(X5) MPLETION DATE	
F 880 Continued From page 99 F 880 (paraplegic), Alzheimer's disease, dementia, and open wound, right lower leg. The quarterly minimum data set (MDS) with an assessment reference date (ARD) of 01/01/2022, in Section C (cognitive patterns) coded Resident #f462* 81MS (brief interview for mental status) score of 99 meaning the resident was unable to complete the interview. Section G (inclineal status) coded the resident required extensive assistance with bed mobility, eating, and toilet use with personal hygiene coded as total dependence. The resident's order summary report contained an order to start on 08/09/2021 with no end date, for contact precautions and read, "Contact precautions for CRE (carbapenem-resistant Enterobacterales) in urine. Staff members providing ADL (activities of daily living) care must wear an isolation gown and gloves when providing ADL care." The care plan's focus areas included, but not limited to, risk for infection due to: incontinence, history of CRE in urine, and right knee abscess with interventions that included contact precautions for CRE in urine and staff members providing ADL care must wear an isolation gown and gloves when providing ADL care. On 02/15/2022 at approximately 1:03 p.m., the surveyor (wearing an N-95 mask and goggles) entered room 210 to meet Resident #162. There was a CNA (certified nursing assistant) assisting the resident with eating. The CNA was wearing a mask and faceshield. The rosident did not respond to the surveyor and continued eating. When the surveyor entering. The ADDN (assistant director of nursing) meet the mesting an N-95 mask and goggles) entered room 210 to meet Resident #162. There was a CNA (certified nursing assistant) assisting the resident was used and caceshield. The resident did not respond to the surveyor entering.			

Facility ID: VA0277

If continuation sheet Page 100 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495019	B. WING				C / 24/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIN	WOODBINE REHABILITATION & HEALTHCARE CENTER				2729 KING ST ALEXANDRIA, VA 22302		
(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 880	surveyor at the door a just hung the contact resident's door while room. The resident h and the precautions s equipment (PPE) card new room until right th knowing Resident #10 precautions and ackn worn a gown and glow why they had not don At approximately 2:30 interviewed again and resident had moved r and there was no con door, the CNA though be on precautions. T indicated that prior to must clean their hand On 02/15/2022 at 9:1 team entered the faci reported everyone was mask and goggles/fac facility. 4. Resident #226's and diagnoses to include, quadriplegia, convers convulsions, resistant lactam antibiotics, and communicate). The r with an assessment r 01/27/2022, in Sectio coded Resident #162 and therefore no BIM status) interview was	and acknowledged having precautions sign on the the surveyor was in the ad recently changed rooms sign and personal protective t had not been moved to the nen. The CNA reported 52 was on contact owledged they should have ves too and did not know ned all of the expected PPE. 0 p.m., the same CNA was d reported that since the ooms (within the same unit) tact precautions sign on the at the resident may no longer he contact precautions sign entering the room everyone is, don gloves and a gown. 5 a.m. when the survey lity, the administrator as required to wear an N-95 ceshield throughout the dmission record listed but not limited to, functional ion disorder with seizures or ce to unspecified beta d aphasia (inability to ninimum data set (MDS) eference date (ARD) of n C (cognitive patterns) as rarely/never understood S (brief interview for mental completed. Section G ded the resident required	F	880			

Facility ID: VA0277

If continuation sheet Page 101 of 104

DEPARTI CENTER	FORM	APPROVED 0.0938-0391						
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495019	B. WING _	B. WING		C 02/24/2022		
NAME OF P	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				27	729 KING ST			
WOODBIN	WOODBINE REHABILITATION & HEALTHCARE CENTER			Α	LEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 880	Continued From page eating, toilet use, and The resident's order s an order, with a start of end date, for contact a 2/24/2022 the director an order dated 2/23/2 Resident #226 that re- remain on contact pre- colonization." The DC had been on contact a 02/10/2022 due to the hospitalization. The of included, but not limited (carbapenem-resistan colonization. The inter limited to, contact isol resident/family/caregi importance of hand w On 02/15/2022 while 2 South, the surveyor (personal protective e room 203 which had a on the door and a car room was semi-privat positive for CRE per t to the precautions sig included gloves after The surveyor was alre and goggles as requir individuals. Upon ent encountered Residen wearing a mask but n faceshield or goggles	e 101 personal hygiene. summary report contained date of 02/10/2022 and no and droplet isolation. On r of nursing (DON) provided 022 at 5:36 p.m., for ead, "The resident is to ecautions for CRE ON reported the resident and droplet precautions on eir readmission from a care plan's focus areas ed to, the resident had CRE at Enterobacterales) erventions included, but not lation and educate vers regarding the rashing. initially meeting residents on donned required PPE equipment) prior to entering a contact precautions sign t with PPE at the door. The e with both residents being the census listed. According n, the PPE required hand hygiene and a gown. eady wearing an N-95 mask red by the facility for all tering the room, the surveyor t #226's mother who was o gown, no gloves, no . The surveyor observed		380				
	legs and moving them	picking up the resident's n around and also touching When asked whether she E required for contact						

Facility ID: VA0277

If continuation sheet Page 102 of 104

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG .		COMPLETED		
		495019	B. WING			C 02/24/2022		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	02/		
WOODBINE REHABILITATION & HEALTHCARE CENTER				:	2729 KING ST			
WOODBIN	WOODBINE REHABILITATION & HEALTHCARE CENTER				ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG			ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
	1				DEFICIENCE)			
F 880	Continued From page	102		880				
1 000		sign on the door or other		000				
		ot respond directly to the						
		226's mother shook her						
		r could not distinguish turing a yes or a no. The						
		e question with no response						
	from the mother. The	assistant director of						
		informed of this observation						
	•	dent #226 had been at the they had spoken with the						
	mother many times.							
		cal record contained a note , dated 02/15/2022 at 5:35						
		ON had spoken with the						
		I reviewed his CRE status.						
		nowing about the resident's						
		so that his sister who was as very knowledgeable						
	-	. The mother understood						
	the need for PPE and							
	-	earing the appropriate PPE self whenever she visits.						
	•	ADON reviewed the need						
		. The surveyor did not have						
		ons of Resident #226's						
	visitors during the sur	vey.						
	The DON provided th	e facility's policy titled,						
	"Isolation - Categorie	s of Transmission-Based						
		ead, in part, that contact						
	known or suspected t	nplemented for residents						
		can be transmitted by direct						
	contact with the resid	ent or indirect contact with						
		es or resident-care items in						
	the resident's environ wear gloves when en	ment. Staff and visitors will tering the room and						
		ygiene performed before						

Facility ID: VA0277

If continuation sheet Page 103 of 104

		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/03/2022 APPROVED . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPL	SURVEY .ETED
		495019	B. WING _			C 02/24/2022	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	STATE, ZIP CODE		
WOODBINE REHABILITATION & HEALTHCARE CENTER				2729 KING ST ALEXANDRIA, VA 223	02		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA" DEFICIENCY)		(X5) COMPLETION DATE
F 880	disposable gown upor removed before leaving The DON was informed regarding Resident # 2/16/2021 at approximal administrator, DON, a were informed of thes 02/16/2022 at 4:00 p. any specific evidence family/caregivers' edu multiple times. The D that read to educate t	aff and visitors will wear a n entering the room and ng the room. ed of the observations 162 and Resident #226 on nately 12:30 p.m. The and assistant administrator we observations on m. The surveyor requested of Resident #226's location regarding PPE OON provided the care plan he family as mentioned prmation was provided prior ey.	F 8	380			

Facility ID: VA0277

If continuation sheet Page 104 of 104