STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced {Medicare/Medicaid} abbreviated survey was conducted on 09/07/2022 through 09/08/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint (VA00054057 -substantiated) was investigated during the survey. The census in this 68 certified bed facility was 22 at the time of the survey. The survey sample consisted of 3 resident reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based clinical record review, staff interviews and in the course of a complaint investigation, the facility staff failed to ensure that residents receive treatment and care in accordance with professional standards of practice for one Resident (Resident #1) in a sample size of 3 Residents. For Resident #1, the facility staff failed to address pacemaker management and monitoring. The findings included:	F 684		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

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F 684	Continued From page 1	F 684		

On 09/07/2022 and 09/08/2022, Resident #1's closed clinical record was reviewed. Resident #1 was admitted to the facility on 03/06/2020 and discharged on 01/01/2022. According to the Discharge Summary from the hospital dated 03/05/2020, Resident #1 had a Medtronic dual chamber permanent pacemaker placed in 2019. According to the list of Medical Diagnoses located under the Medical Diagnosis Tab in the facility's electronic health record, Resident #1's admission diagnoses included but were not limited to chronic atrial fibrillation and the presence of a pacemaker.

A review of the physician's orders in the electronic health record revealed that were no orders addressing Resident #1's pacemaker.

A review of Resident #1's care plan was reviewed. Pacemaker details and monitoring were not addressed in the plan of care.

The progress notes for June 2021 were reviewed. An excerpt of a nurse's note dated 06/01/2021 at 11:57 P.M. under the header "Daily Documentation" and sub-header "Cardiovascular" it was documented, "Pacemaker: No." Subsequent nurse's notes dated 06/02/2021, 06/04/2021, 06/06/2021, 06/09/2021, 06/14/2021, 06/20/2021, 06/21/2021, and 06/25/2021 all documented that Resident #1 did not have a pacemaker. A nurse's note dated 06/15/2021 at 12:36 P.M. under the header "Daily Documentation" and sub-header "Cardiovascular" it was documented, "Pacemaker: Yes. Last Pacemaker check: [blank]."

A provider note written by Employee G, a Nurse Practitioner, dated 06/23/2021 at 3:31 P.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 2	F 684		

entitled, "Nursing request patient visit for monthly visit to recertify medical care plan" did not document the presence of a pacemaker.

An excerpt of a provider note written by Employee F, a Nurse Practitioner, dated 12/10/2021 at 6:57 P.M. under the header "A&P [Assessment and Plan]" documented, "AICD [Automated Implantable Cardioverter-Defibrillator which is not a pacemaker] rate unkn [unknown], f/u [follow up] Cardiology [Center Name] PRN [as needed]."

On 09/08/2022 at 12:40 P.M., Employee F, the Nurse Practitioner, was interviewed. When asked about Resident #1's pacemaker, the Nurse Practitioner stated that Resident #1 did have a pacemaker. The Nurse Practitioner went on to explain that Resident #1 had atrial fibrillation so usually the pacemaker would be set at a rate but they did not receive any paperwork about the rate settings. The Nurse Practitioner then stated that "It's up to the POA [power of attorney] to schedule appointments and follow up with the specialist." The Nurse Practitioner further stated that "The cardiologist should've told the POA about scheduling appointments for follow ups and pacemaker checks."

On 09/08/2022, the administrator was notified of findings. The administrator provided a copy of their policy entitled, "Pacemaker Monitoring" as requested. Under the header "Policy Statement" it was documented, "It is the policy of [Company Name] and its affiliates to assure that residents with a pacemaker will have monitoring and safety precautions in place." In Section I under the header "Procedure", it was documented, "If the resident has a pacemaker the type will be identified in the Physician's Order Sheet." In

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

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F 684	Continued From page 3 Section II, it was documented, "The physician will order the frequency with which the monitoring checks are to be performed." In Section V, it was documented, "Preference for monitoring checks will be documented on the Physician's Order Sheet." In Section VI, it was documented, "Monitoring preferences shall be included in the resident's service plan."	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident and family interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure care was provided to prevent the worsening of pressure injuries for one Resident (Resident #3) in a sample size of 3 Residents. For Resident #3, the facility staff failed to perform skin assessments from 07/15/2022 through 08/04/2022.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 4	F 686		

The findings included:

On 09/07/2022 at 3:05 P.M., Resident #3 and their spouse were interviewed. When asked if he had any wounds, wound treatments, or required any dressing changes, Resident #3 and their spouse stated that Resident #3 currently did not have any skin issues.

On 09/07/2022 and 09/08/2022, Resident #3's clinical record was reviewed. A physician's order dated 07/20/2022 documented, "Apply skin prep to right heel redness every day and every evening shift for wound care." A physician's order dated 07/20/2022 documented, "Apply skin prep to left heel redness every day and every evening shift for wound care." A physician's order dated 07/20/2022 documented, "Float heels when in bed as resident permits q[every] shift." A physician's order dated 07/20/2022 documented, "Pressure reduction mattress on bed."

Resident #3's care plan was reviewed. A focus dated 07/21/2022 entitled, "The resident is potential for pressure ulcer development r/t [related to] impaired mobility and incontinent of both bowel and bladder." An intervention associated with this focus documented, "Float both heels when in bed. Apply skin prep as order [sic] for protection." There was not an intervention to perform weekly skin assessments.

An admission skin assessment dated 07/15/2022 at 5:54 P.M. indicated that Resident #3 had bruising of the right elbow, a deep tissue injury on the scrotum, a rash on the back, red heels, and a deep tissue injury of the great toe [did not specify right versus left]. For the deep tissue injury of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

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F 686	Continued From page 5	F 686		

scrotum, there were no measurements of the area. For the red heels, there were no measurements of the reddened areas and the precise location of the redness was not addressed. For the deep tissue injury of the great toe, there were no measurements and which toe was involved was not documented.

There was not another skin assessment document (Skin Observation Tool) until 08/04/2022 at 6:38 P.M. which indicated that Resident #3 had a rash on his face, bruising of the right elbow, a rash on the scrotum, a blister on the right toe and pressure to the bilateral heels (no measurements included).

On 09/08/2022 at 8:15 A.M., the Director of Nursing (DON) was interviewed. When asked about the expectation for skin assessments, the DON stated that skin assessment should be done on admission and weekly. When ask why the skin should be assessed weekly, the DON stated it is done to track and skin issues. The DON went on to explain that residents with impaired mobility are at risk for skin breakdown so the skin must be assessed on a weekly basis so any issues will be identified early. When asked about wound measurements, the DON stated she expects the wound doctor and the wound nurse to measure the wounds.

On 09/08/2022 at 10:00 A.M., the wound nurse was interviewed. When asked about Resident #3's admission skin assessment, the wound nurse stated that Resident #3 did not have a deep tissue injury of his great toe. The wound nurse stated that he had redness on his toe and heels from his shoes and the redness went away when they removed his shoes and floated his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

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F 686	Continued From page 6	F 686		

heels. The wound nurse also stated that Resident #3 had a rash on his scrotum, not a deep tissue injury as indicated on the admission skin assessment. When asked about the expectation for skin assessments, the wound nurse stated that residents should have weekly skin assessments and confirmed that Resident #3 did not have weekly skin assessments documented. The wound nurse also stated that a physician's order for weekly skin assessments was not required because it was a part of their wound protocol.

On 09/08/2022 at 2:00 P.M., this surveyor and the wound nurse entered Resident #3's room for a skin observation. Both of Resident #3's heels were reddened. Both heels were blanchable but had delayed capillary refill (greater than 3 seconds). When asked about this, the wound nurse stated that this was Resident #3's baseline.

The facility staff provided a copy of their policy entitled, "Pressure Injuries and Surgical Sites for Licensed Nurses." In Section V(a)(b) documented the following excerpt: "Licensed nurses are to document a weekly evaluation of a resident's skin using the weekly Skin Observation Tool in the clinical software. Licensed nurses weekly evaluation documentation of pressure injuries is to include measurements in centimeters by Length by Width and by Depth, appearance of the pressure injury and wound bed, any drainage-amount and type, redness or warmth of surrounding tissue that is new and any odor coming from the wound."

On 09/08/2022 at approximately 5:00 P.M., the administrator and DON were notified of findings and they stated there was no further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

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F 686	Continued From page 7 documentation to submit.	F 686		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		

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	495288	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

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F 842	Continued From page 8	F 842		

purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to maintain a complete and accurate clinical record for 1 Resident (Resident #1) in a sample size of 3 Residents.

For Resident #1,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

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F 842	Continued From page 9	F 842		

(a) there was conflicting information in the clinical record pertaining to Resident #1's pacemaker.
(b) evidence of lab results and a medication administration was not in the clinical record.

The findings included:

On 09/07/2022 and 09/08/2022, Resident #1's closed clinical record was reviewed. Resident #1 was admitted to the facility on 03/06/2020 and discharged on 01/01/2022. According to the Discharge Summary from the hospital dated 03/05/2020, Resident #1 had a Medtronic dual chamber permanent pacemaker placed in 2019. According to the list of Medical Diagnoses located under the Medical Diagnosis Tab in the electronic health record, Resident #1's admission diagnoses included but were not limited to chronic atrial fibrillation and the presence of a pacemaker.

A review of the physician's orders in the electronic health record revealed that were no orders addressing Resident #1's pacemaker.

A review of Resident #1's care plan was reviewed. The pacemaker was not addressed in the plan of care.

The progress notes for June 2021 were reviewed. An excerpt of a nurse's note dated 06/01/2021 at 11:57 P.M. under the header "Daily Documentation" and sub-header "Cardiovascular" it was documented, "Pacemaker: No." Subsequent nurse's notes dated 06/02/2021, 06/04/2021, 06/06/2021, 06/09/2021, 06/14/2021, 06/20/2021, 06/21/2021, and 06/25/2021 all documented that Resident #1 did not have a pacemaker. A nurse's note dated 06/15/2021 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 10	F 842		

12:36 P.M. under the header "Daily Documentation" and sub-header "Cardiovascular" it was documented, "Pacemaker: Yes. Last Pacemaker check: [blank]."

A provider note written by Employee G, a Nurse Practitioner, dated 06/23/2021 at 3:31 P.M. entitled, "Nursing request patient visit for monthly visit to recertify medical care plan" did not document the presence of a pacemaker.

An excerpt of a provider note written by Employee F, a Nurse Practitioner, dated 12/10/2021 at 6:57 P.M. under the header "A&P [Assessment and Plan]" documented, "AICD [Automated Implantable Cardioverter-Defibrillator which is not a pacemaker] rate unkn [unknown], f/u [follow up] Cardiology [Center Name] PRN [as needed]."

On 09/08/2022 at 12:40 P.M., Employee F, the Nurse Practitioner, was interviewed. When asked about Resident #1's pacemaker, the Nurse Practitioner confirmed that Resident #1 did have a pacemaker.

On 09/07/2022 and 09/08/2022, Resident #1's closed clinical record was reviewed.

An excerpt of a Care Plan Meeting noted 03/10/2021 documented, "Nursing updated the son about resident's status ...and that resident has appointment for Prolia injection with the immunization clinic on 03/15/21 at 3:30 PM." An excerpt of a health status note dated 03/15/2021 at 3:12 P.M. documented, " Resident has an [sic] follow up appointment, pt [patient] LOA [leave of absence] with son (RP [responsible party]). " The note did not explicitly state which follow up appointment it was or confirm Resident #1 went

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

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F 842	Continued From page 11	F 842		

to the immunization clinic and received the Prolia injection.

An excerpt of a provider note written by Employee G, a nurse practitioner, dated 06/23/2021 at 3:31 P.M. documented, "Pt [patient] saw immunization clinic on 03/15 for Prolia appointment.

A note dated 09/10/2021 at 4:32 P.M. documented, "[Nurse Practitioner] was made aware that resident has appointment with immunization clinic for Prolia injection as per RP(son) on 09/16/21 and that orders for labs (BMP, Calcium) needed to be done prior to appointment. Order was given, labs drawn, results pending. "There was no evidence in the clinical record of the lab results. A review of the nurse's notes around the time of the scheduled appointment on 09/16/2021 revealed that there was no evidence Resident #1 went the immunization clinic that day for the Prolia injection.

On 09/08/2022, the administrator and Director of Nursing were notified of findings. The administrator provided documents from their outside resource laboratory and physician's office [not part of the Resident #1's facility clinical record] providing evidence that Resident #1 had labs drawn and received a Prolia injection on 03/15/2021 and 09/16/2021.