DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/10/23 through 1/12/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare / Medicaid standard survey was conducted 1/10/23 through 1/12/23. One complaint was investigated during the survey (VA00054207 - substantiated with deficiencies). Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 31 certified bed facility was 28 at the time of the survey. The survey sample consisted of 14 current Resident reviews and three closed record reviews.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623	**F623** 1. **With respect to the specific observation cited:** On 1/24/23, the MDS Coordinator was able to locate a written notice; including orders to transfer and fax information to the Office of the State Long-Term Care Ombudsman of a hospital transfer for Resident #10 on 9/21/23 at 2:41, sent by RN. 2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** The hospital transfer log was reviewed by the DON to verify all current residents who have had a hospital transfer from this facility within the past 30 days have a faxed notice to the Local Ombudsman. There were no findings of other residents having the potential to be affected by this	

deficient practice.

3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training on procedures to follow after hospital transfer, including notification to the Local Ombudsman, was provided to the nursing team by the Director of Nursing on 1/26/23. Over the next three months, the hospital transfer log will be audited monthly by Director of Nursing or her designee to verify all hospital transfers are reported to the Local Ombudsman timely.
4. **With respect to how the plan or corrective measures will be monitored:** The findings of the hospital transfer log audits will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. During and after the conclusion of the three-month period, the QA committee will re-evaluate and initiate necessary action or extend the review period if needed. The Administrator is responsible for confirming implementation.
5. **Areas cited in F623 will corrected by 2/22/23.**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2/14/23

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.

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F 623	Continued From page 1 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in	F 623		

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F 623	Continued From page 2	F 623		

completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §

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F 623	Continued From page 3 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide a written notice to the Office of the State Long-Term Care Ombudsman of a hospital transfer for one of 17 residents in the survey sample; Resident #10. The findings include: The facility staff failed to provide a written notice to the ombudsman about a hospital transfer when Resident #10 was transferred to the hospital on 9/21/22. A review of the clinical record revealed a nurse's note dated 9/21/22 that documented, "Guest left the facility at about 1430 (2:30 PM) on transfer to [name of hospital] emergency room via [name of company] transportation as ordered." A physician's progress note dated 9/21/22 documented, " ... Pt (patient) is complaining of chest pains .... Pt is being sent to the ER (emergency room) for further eval (evaluation).... " Review of the clinical record failed to reveal any evidence of written notification to the ombudsman. On 1/12/23 at 8:35 AM, in an interview with ASM #1 (Administrative Staff Member), the Administrator, she stated that the facility does not send an ombudsman notice for a resident who is not admitted to the hospital and came back. At 2:24 PM, she stated that it is not required in this scenario.	F 623		

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F 623	Continued From page 4 On 1/12/23 at approximately 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. ASM #1 was provided a list of policies being requested. The list included one for ombudsman notification when a resident is discharged to the hospital. None was provided. No further information was provided by the end of the survey.	F 623		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655	**F655** 1. **With respect to the specific observation cited:** Resident #176 has discharged from the facility. Resident #18's Responsible Party spoke with ASM #1 on 1/24/23, the baseline care plan was discussed, it was distributed to the Responsible Party, with a signature page that was placed in resident's medical chart. Resident #174 was presented with her baseline care plan on 1/24/23 by the ASM #1. The care plan for Resident #23 was updated and corrected to reflect the current compression stocking order at the time of survey. 2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** All residents can potentially be affected by this	

deficient practice due to lack of notifications as it pertaining to care.

3. **With respect to what systemic measures have been put in place to address the stated concern:** . Refresher training on baseline care plans was conducted on 1/17/23 by the Administrator and MDS coordinator for nursing staff. Audits will be conducted weekly for all new admissions for three months by the Director of Nursing or her designee to verify the baseline care plans are being developed and presented and reflect current orders.

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F 655	Continued From page 5 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, the facility staff failed to develop and/or provide residents and/or their responsible party, with a summary of the baseline care plan for five of 17 residents in the survey sample, Residents #176, #18, #177, #174 and #23. The findings include: 1. For Resident #176 (R176), the facility staff failed to provide the resident and/or the responsible party with a summary of the baseline care plan. R176 was admitted to the facility on 1/1/2023. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/8/2023, the resident scored	F 655	4. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings from the baseline care plan audits will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Administrator is responsible for ensuring implementation and ongoing compliance with the components of the Plan of Correction and addressing resolving variances that may occur. 5. **Areas cited in F655 will be corrected by 2/23/23.**	

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F 655	Continued From page 6 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 1/11/2023 at 9:42 a.m., an interview was conducted with R176 in their room. When asked about receiving a written summary of their baseline care plan, R176 stated that they did not recall receiving anything however their children were involved and may have gotten something. A review of R176's clinical record failed to evidence a written summary of the baseline care plan being provided to the resident and/or the responsible party. On 1/12/2023 at approximately 8:30 a.m., a request was made to ASM #1, the administrator for evidence of the baseline care plan being provided to R176 and/or the responsible party. On 1/12/2023 at 9:57 a.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator/Infection preventionist. RN #1 stated that the floor nurses were responsible for developing the baseline care plan. RN #1 stated that it was the assistant director of nursing's responsibility to ensure the baseline care plan was completed within twenty-four hours and to provide the resident and/or the responsible party with a written copy and explain to them that it was a basic plan of care. RN #1 stated that they currently did not have an assistant director of nursing and were not sure if the written copy was being provided. On 1/12/2023 at 10:42 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. ASM #2 stated	F 655		

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F 655	Continued From page 7	F 655		

that the floor nurses were responsible for developing the baseline care plan based on the concerns the resident was admitted with. ASM #2 stated that the resident and/or responsible party should have access to and have a copy of the care plan. ASM #2 stated that they were onboarding at the facility and would have to check the process to see whether residents and/or the responsible parties were getting a written summary of the baseline care plan.

On 1/12/2023 at 3:16 p.m., ASM #1 stated that they did not have evidence of a written summary of the baseline care plan being provided to R176 and/or the responsible party.

On 1/12/2023 at approximately 3:20 p.m., ASM #1 was made aware of the concern.

No further information was provided prior to exit.

2. For Resident #18 (R18), the facility staff failed to provide the resident and/or the responsible party with a summary of the baseline care plan.

R18 was admitted to the facility on 12/06/2022. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/13/2022, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions.

On 1/11/2023 at 9:15 a.m., an interview was conducted with R18 in their room. When asked about receiving a written summary of their baseline care plan, R18 stated that they were unsure.

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F 655	Continued From page 8 A review of R18's clinical record failed to evidence a written summary of the baseline care plan being provided to the resident and/or the responsible party. On 1/12/2023 at approximately 8:30 a.m., a request was made to ASM #1, the administrator for evidence of the baseline care plan being provided to R18 and/or the responsible party. On 1/12/2023 at 9:57 a.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator/Infection preventionist. RN #1 stated that the floor nurses were responsible for developing the baseline care plan. RN #1 stated that it was the assistant director of nursing's responsibility to ensure the baseline care plan was completed within twenty-four hours and to provide the resident and/or the responsible party with a written copy and explain to them that it was a basic plan of care. RN #1 stated that they currently did not have an assistant director of nursing and were not sure if the written copy was being provided. On 1/12/2023 at 10:42 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. ASM #2 stated that the floor nurses were responsible for developing the baseline care plan based on the concerns the resident was admitted with. ASM #2 stated that the resident and/or responsible party should have access to and have a copy of the care plan. ASM #2 stated that they were onboarding at the facility and would have to check the process to see whether residents and/or the responsible parties were getting a written summary of the baseline care plan.	F 655		

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F 655	Continued From page 9 On 1/12/2023 at 3:16 p.m., ASM #1 stated that they did not have evidence of a written summary of the baseline care plan being provided to R18 and/or the responsible party. On 1/12/2023 at approximately 3:20 p.m., ASM #1 was made aware of the concern. No further information was provided prior to exit. 3. For Resident #177 (R177), the facility staff failed to provide the resident and/or the responsible party with a summary of the baseline care plan. R177 was admitted to the facility on 10/28/2022. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 11/25/2022, the resident scored 1 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. A review of R177's clinical record failed to evidence a written summary of the baseline care plan being provided to the responsible party. On 1/12/2023 at approximately 8:30 a.m., a request was made to ASM #1, the administrator for evidence of the baseline care plan being provided to R177 and/or the responsible party. On 1/12/2023 at 9:57 a.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator/Infection preventionist. RN #1 stated that the floor nurses were responsible for developing the baseline care plan. RN #1 stated that it was the assistant director of nursing's	F 655		

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F 655	Continued From page 10	F 655		

responsibility to ensure the baseline care plan was completed within twenty-four hours and to provide the resident and/or the responsible party with a written copy and explain to them that it was a basic plan of care. RN #1 stated that they currently did not have an assistant director of nursing and were not sure if the written copy was being provided.

On 1/12/2023 at 10:42 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. ASM #2 stated that the floor nurses were responsible for developing the baseline care plan based on the concerns the resident was admitted with. ASM #2 stated that the resident and/or responsible party should have access to and have a copy of the care plan. ASM #2 stated that they were onboarding at the facility and would have to check the process to see whether residents and/or the responsible parties were getting a written summary of the baseline care plan.

On 1/12/2023 at 3:16 p.m., ASM #1 stated that they did not have evidence of a written summary of the baseline care plan being provided to R177 and/or the responsible party.

On 1/12/2023 at approximately 3:20 p.m., ASM #1 was made aware of the concern.

No further information was provided prior to exit.

4. For Resident #174 (R174), the facility staff failed to provide the resident and/or the responsible party with a summary of the baseline care plan.

R174 was admitted to the facility on 1/9/2023.

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F 655	Continued From page 11	F 655		

R174's MDS (minimum data set) assessment was not due during the dates of the survey. The admission health assessment dated 1/9/2023 documented R174 being modified independent with decisions regarding tasks of daily life.

A review of R174's clinical record failed to evidence a written summary of the baseline care plan being provided to the responsible party.

On 1/12/2023 at approximately 8:30 a.m., a request was made to ASM #1, the administrator for evidence of the baseline care plan being provided to R174 and/or the responsible party.

On 1/12/2023 at 9:57 a.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator/Infection preventionist. RN #1 stated that the floor nurses were responsible for developing the baseline care plan. RN #1 stated that it was the assistant director of nursing's responsibility to ensure the baseline care plan was completed within twenty-four hours and to provide the resident and/or the responsible party with a written copy and explain to them that it was a basic plan of care. RN #1 stated that they currently did not have an assistant director of nursing and were not sure if the written copy was being provided.

On 1/12/2023 at 10:42 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. ASM #2 stated that the floor nurses were responsible for developing the baseline care plan based on the concerns the resident was admitted with. ASM #2 stated that the resident and/or responsible party should have access to and have a copy of the care plan. ASM #2 stated that they were

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 655	Continued From page 12	F 655		

onboarding at the facility and would have to check the process to see whether residents and/or the responsible parties were getting a written summary of the baseline care plan.

On 1/12/2023 at 3:16 p.m., ASM #1 stated that they did not have evidence of a written summary of the baseline care plan being provided to R174 and/or the responsible party.

On 1/12/2023 at approximately 3:20 p.m., ASM #1 was made aware of the concern.

No further information was provided prior to exit.
5. For Resident #23 (R23), the facility staff failed to develop a baseline care plan to include the resident's compression stockings.

R23 was admitted to the facility on 12/30/22. On the admission assessment dated 12/20/22, R23 was assessed to have both long term and short term memory problems. R 23 was admitted following recent surgery to repair a broken hip.

On 1/11/23 at 9:35 a.m., 10:51 a.m., and 1:44 p.m., R23 was sitting up in bed. The resident was not wearing compression stockings at any of these times.

A review of R23's physician's orders revealed the following order dated 1/6/23: "Compression stockings Midgrade to the knee (BLE) in the morning and remove per schedule."

A review of R23's baseline care plan failed to reveal any information regarding compression stockings.

On 1/12/23 at 9:15 a.m., RN (registered nurse)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 655	Continued From page 13 #4 was interviewed. She stated she had worked the night shift, and thought she had helped remove R23's compression stockings at bedtime on 1/11/23, but could not be sure. She stated she was not sure how staff knew to apply compression stockings to a resident's legs. She stated she did not know who was responsible for developing a resident's baseline care plan. On 1/12/23 at 9:56 a.m., RN #1, the MDS coordinator, was interviewed. She stated the admitting nurse is responsible for initiating the care plan. She stated ordinarily the assistant director of nursing is responsible for completing the baseline care plan. She stated there is no current assistant director of nursing. On 1/12/23 at 10:41 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated the admitting nurse puts together a care plan of what they identify as the resident's needs. She stated compression stockings should be included on a baseline care plan. On 1/12/23 at 12:28 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. No further information was provided prior to exit.	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658	**F658** 1. **With respect to the specific observation cited:** RN #2 was reeducated by the DON and MDS Coordinator on 1/12/23 on how to properly administer Lactulose. The resident had no adverse outcomes from the improper administration of the medication. 2. **With respect to how the facility will identify residents with the**	

potential for the identified concern and take corrective action: All residents can potentially be affected by this deficient practice as it pertains to all medications as a whole administered to all residents.

3. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** The Director of Nursing on 1/27/23 performed a chart review to determine which residents have an order for Lactulose. 2 other residents were identified.
4. **With respect to what systemic measures have been put in place to address the stated concern:** Education was conducted with the nursing staff by the Director of Nursing by 1/30/23 regarding medication administration, with emphasis of liquid medications for accurate measurement and doses to be administered.
   Director of Nursing will conduct medication administration observations of 3 nurses each week for the first month then biweekly for 2 more months to verify proper administration of all medications.
5. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings from medication pass observations will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. At the conclusion of the three-month period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing

	compliance with the components of this Plan of Correction and addressing along with resolving variances that may occur. 6. **Areas cited in F658 will be corrected by 2/23/23.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 658	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to follow professional standards of practice for medication administration for one of six residents in the medication administration task; Resident #174. The findings include: For Resident #174, the facility staff failed to properly prepare a dose of the medication, Lactulose (1), for administration. A review of the physician's orders revealed one dated 1/9/23 for Lactulose 20 GM (grams) / 30 ML (milliliters), give 15 ml one time a day. On 1/11/23 at 9:21 AM, RN #2 (Registered Nurse) was observed to prepare and administer medications to Resident #174. For the administration of the Lactulose, which was supplied in a 30 ml cup, RN #1 did not measure out the 15 ml ordered dose. Instead, RN #2 encouraged the resident to consume the medication from the prefilled 30 ml cup and then estimated when the resident had consumed approximately half of the cup, then discarded the rest. On 1/11/23 at 5:18 PM an interview was conducted with RN #2. She stated that she should have measured out the correct dose of the medication to be sure the resident received exactly what was ordered. A review of the facility policy, "Community Medication Oversight Program" did not provide	F 658		

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	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 658	Continued From page 15 any procedures on how to administer medications, including the steps involved in preparing and dosing medications accurately. On 1/12/23 at approximately 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter, page 707, "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication, 2. The right dose, 3. The right client, 4. The right route, 5. The right time, and 6. The right documentation." References: (1) Lactulose is used to treat constipation Information obtained from https://medlineplus.gov/druginfo/meds/a682338.html	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684	**F684** 1. **With respect to the specific observation cited:** Resident #23 was assisted with donning compression stockings during survey period. Care tasks were updated so the C.N.A. could see the task on their list. The Registered Dietician provided a breakdown of how fluids should be consumed and distributed the information to the	

nursing and dietary teams and updated the order to allow nurse to record amount of fluid consumed each shift. Resident #7's fluid restriction orders were reviewed by nursing team on 1/26/23 along with fluid restriction metrics; addressing clarification of orders.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** The Director of Nursing conducted an audit of residents who currently have orders for compression stockings on 1/25/23. No other residents with orders for compression stockings were identified. Audits of fluid restriction orders will also be conducted by the Director of Nursing weekly to ensure nursing staff is utilizing fluid restriction metrics required for adequate fluid restriction intake and documentation for one month.
3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training was conducted on 1/26/23 with nursing staff by the Director of Nursing regarding placement of compression stockings for residents to reflect current orders. Training and in-services with nursing staff were conducted by the Director of Nursing on 1/26/23 regarding proper fluid restriction protocol. Director of Nursing or designee will audit orders weekly to identify any residents with orders for compression stockings or fluid restrictions. Director of Nursing or designee will conduct observations to verify that compression stockings are being applied and fluid restrictions are being followed

	as ordered. 4. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings from weekly observations will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. At the conclusion of the three-month period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing along with resolving variances that may occur. 5. **Areas cited in F684 will be corrected by 2/22/23.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 684	Continued From page 16 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 on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide clinical services in a manner to promote a resident's highest level of well-being for two of 17 residents in the survey sample, Residents #23 and #7. The findings include: 1. For Resident #23 (R23), the facility staff failed to apply compression stockings per a physician's order. R23 was admitted to the facility on 12/30/22. On the admission assessment dated 12/20/22, R23 was assessed to have both long term and short term memory problems. R 23 was admitted following recent surgery to repair a broken hip. On 1/11/23 at 9:35 a.m., 10:51 a.m., and 1:44 p.m., R23 was sitting up in bed. The resident was not wearing compression stockings at any of these times. A review of R23's physician's orders revealed the following order dated 1/6/23: "Compression stockings Midgrade to the knee (BLE) in the morning and remove per schedule."	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 17	F 684		

A review of R23's baseline care plan failed to reveal any information regarding compression stockings.

On 1/12/23 at 9:15 a.m., RN (registered nurse) #4 was interviewed. She stated she had worked the night shift, and thought she had helped remove R23's compression stockings at bedtime on 1/11/23, but could not be sure. She stated she was not sure how staff knew to apply compression stockings to a resident's legs.

On 1/12/23 at 9:49 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated she had been assigned to R23 on 1/11/23. She stated she did not put compression stockings on the resident on 1/11/23. She stated she did not know the resident needed compression stockings. She stated things like compression stockings show on her instructions in the EMR (electronic medical record), but she did not see those instructions for R23.

On 1/12/23 at 12:28 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. Policies regarding compression stockings were requested, but not received prior to exit.

No further information was provided prior to exit.

2. For Resident #7 (R7), who had a physician's order for fluid restriction, the facility failed to document the amount of fluid the resident received each shift.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 684	Continued From page 18	F 684		

reference date) of 11/9/22, R7 was coded as cognitively intact for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status).

On 1/10/23 at 1:18 p.m., 1/11/23 at 9:35 a.m. and 10:22 a.m., R7 was sitting up in the room. At each observation, the resident had a small pitcher of water within reach. At each observation, the resident was unable to reliably answer questions about fluid intake.

A review of R7's clinical record revealed the following order dated 11/27/22: "Fluid restriction < 1.2 liters (less than 1.2 liters) a day every shift."

A review of R7's TARs (treatment administration records) from November and December 2022, and from January 2023, revealed nurse initials and check marks for each shift in the fluid restriction area. There were no amounts of fluid in any of the TARs.

A review of R7's care plan dated 11/28/22 revealed no information related to the fluid restriction.

On 1/12/23 at 9:15 a.m., RN (registered nurse) #4 was interviewed. When asked if she had signed any of R7's TARs related to fluid restriction, she said she had done so. When asked what the check mark in the box meant, she stated, "It means the resident is taking fluid as stated." When asked if there is any way to look at the TARs to determine how much fluid a resident is receiving each shift, and from both nursing and dietary, she stated, "No. There is not." When asked how much fluid R7 receives on the trays from dietary as opposed to how much fluid

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	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 684	Continued From page 19	F 684		

nursing is allowed to administer with medications, she stated she did not know. She stated the resident usually has a 500 ml (milliliter) bottle of water at the bedside, and she tries to measure how much water the resident is drinking from it. When asked where she documents that amount, she stated, "I don't really document it." When asked if all staff are following this procedure, she stated, "I don't know."

On 1/12/23 at 9:56 a.m., RN #1, the MDS coordinator, was interviewed. She stated she could not determine how much fluid the resident should be receiving on any shift, and could not say how much fluid the resident was actually receiving. She stated there was no way the facility could know whether the resident was receiving the correct amount of fluids with the way the TAR was currently structured.

On 1/12/23 at 12:28 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy, "Fluid Restriction," revealed, in part: "It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders...The nurse will obtain and verify the physician's order for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department, and will be recorded on the medication record or other format as per facility protocol...The fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 684	Continued From page 20 No further information was provided prior to exit.	F 684	**F695** 1. **With respect to the specific observation cited:** Oxygen order was clarified for resident #17 with physician during survey. Resident did not have any adverse effects from not receiving oxygen when it was ordered. 2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** Other residents having the potential to be affected by the same deficient practice will be identified upon admission and/or physician orders by the Director of Nursing or designee. No other residents were identified with unclear orders. 3. **With respect to what systemic measures have been put in place to address the stated concern:** On 1/26/23, Refresher training/in-service was conducted by the Director of Nursing to educate nurses on the need to clarify orders if they are not clearly written and to verify that residents with oxygen orders are receiving it as prescribed. The Director of Nursing and/or designee will conduct weekly observations for 3 months on residents receiving oxygen to verify that oxygen use reflects the current physician orders.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility failed to follow and clarify an order for oxygen for one of 17 residents in the survey sample, Resident #17. The findings include: For Resident #7 (R7), the facility failed to clarify an order for oxygen, and to administer oxygen as ordered. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/9/22, R7 was coded as cognitively intact for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status). The resident was coded as receiving oxygen prior to admission and during the look back period at the facility. On 1/10/23 at 1:18 p.m., 1/11/23 at 9:35 a.m. and	F 695		

	4. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings from weekly observations will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. At the conclusion of the three-month period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing along with resolving variances that may occur. 5. **Areas cited in F695 will be corrected by 2/22/23.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 695	Continued From page 21 10:22 a.m., R7 was receiving oxygen via a nasal cannula from an oxygen concentrator. The concentrator was set at 1.5 lpm (liters per minute). A review of R7's clinical record revealed the following order dated 11/28/22: "Oxygen 0.5L (liter) to 1L at bedtime." A review of R7's care plan dated 11/28/22 revealed nothing specifically related to the liters per minute or timing of oxygen administration. On 1/12/23 at 9:15 a.m., RN (registered nurse) #4 was interviewed. When asked to review R7's oxygen order, she stated it was unclear as to how much the oxygen the resident was supposed to be receiving. She stated the order provided clear instructions that the resident should only be receiving oxygen at night. On 1/12/23 at 10:41 a.m., RN #1, the MDS coordinator, was interviewed. After reviewing R7's oxygen order, she stated the order needed to have parameters set, and needed to be clarified. She stated the order was not being followed as currently written because the resident was receiving the oxygen during the daytime. On 1/12/23 at 12:28 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. Policies regarding oxygen administration were requested, but not received prior to exit. No further information was provided prior to exit.	F 695		
F 697 SS=E	Pain Management	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 697	Continued From page 22 CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide a complete pain management program including implementation of non-pharmacological interventions prior to the administration of as-needed pain medications for two of 17 residents in the survey sample, Residents #177 and #19. The findings include: 1. For Resident #177 (R177), the facility staff failed to evidence implementation of non-pharmacological interventions prior to administration of as-needed pain medication. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 11/25/2022, the resident scored 1 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section J documented R177 receiving as needed pain medications and not receiving non-medication interventions for pain. The physician order's for R177 documented in	F 697	**F697** 1. **With respect to the specific observation cited:** Resident #177 is offered repositioning and turning as a non-pharmacological intervention for pain. Non-pharmacological interventions will be presented prior to PRN medications being administered by nursing staff. Resident #19 discharged facility on 1/26/22; priorthe non-pharmacological intervention education that took place with all nursing staff by the DON on 1/26/23. 2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** Other residents having the potential to be affected by the same deficient practice will be identified upon admission. The Director of Nursing and/or designee will review and audit all MD orders weekly for 3 months to assure all orders reflect interventions as needed. 3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training was held on 1/26/23 by Director of Nursing regarding the process of offering non-pharmacological interventions to each resident prior to administering pain medication. Daily skilled notes and MARS will be audited weekly by the Director of Nursing and/or designee to verify documentation of non-	

	pharmacological interventions are being discussed and offered to residents with pain. 4. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings from weekly audits will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. At the conclusion of the three-month period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing along with resolving variances that may occur. 5. **Areas cited in F697 will be corrected by 2/22/23.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 23	F 697		

part,
- "Tylenol Oral Tablet 325 MG (milligram) (acetaminophen (1)) Give 2 tablet by mouth every 6 hours as needed for pain. Do not exceed 3 grams in 24 hours from all sources. Order Date: 10/28/2022. Start Date: 10/28/2022."

The eMAR (electronic medication administration record) dated 11/1/2022-11/30/2022 documented the Tylenol as administered to R177 on 11/2/2022 for a pain level of six; on 11/5/2022 for a pain level of three; on 11/19/2022 for a pain level of three; and on 11/30/2022 for a pain level of two.

The eMAR dated 12/1/2022-12/31/2022 documented the Tylenol as administered to R177 on 12/17/2022 for a pain level of four.

The progress notes for R177 failed to evidence documentation of non-pharmacological interventions attempted or offered prior to the administration of the as needed pain medication on the dates and times listed above.

The comprehensive care plan for R177 dated 10/28/2022 documented in part, "The resident is on pain medication therapy r/t (related to) sacral wound. Date Initiated: 10/28/2022. Revision on: 10/28/2022..."

On 1/12/2023 at 1:54 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated that when residents complained of pain they did a pain assessment first and then attempted non-pharmacological interventions like repositioning prior to administering pain medications. RN #2 stated that they would ask the resident to rate their pain or use the non-verbal scale if needed and administer the as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 697	Continued From page 24	F 697		

needed medication when the non-pharmacological interventions were not effective. RN #2 stated that they documented the non-pharmacological interventions they attempted in the progress notes. RN #2 stated that if there were no progress notes to evidence the non-pharmacological interventions were attempted that it meant the nurse when straight to the pain medications, maybe because the residents pain was so intense. RN #2 stated that it was key to document what non-pharmacological interventions were used and their system had a process to allow them to enter the notes when administering medications.

The facility policy "Pain Management Program" dated 1/2019 documented in part, "...An effective pain management plan uses a multi-pronged approach. Pharmacologic therapy is a mainstay of treatment, but non-pharmacologic interventions are equally as important...Consider using multiple nondrug therapies to better meet resident's individual needs. All interventions are evaluated and documented in the same way as medication therapy. The licensed nurse and other members of the interdisciplinary team observe and evaluate interventions and their effectiveness in relieving the resident's pain. The resident's response is documented and the licensed nurse discusses the interventions and their effectiveness with the healthcare provider and they collaborate with the resident and legal representative to develop additional interventions and make revisions to the resident's pain management plan..."

On 1/12/2023 at approximately 2:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the concern.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 697	Continued From page 25	F 697		

No further information was provided prior to exit.

2. For Resident #19, the facility staff failed to evidence non-pharmacological interventions were attempted prior to administration of as-needed (PRN) pain medication.

On the most recent MDS (Minimum Data Set), an admission / 5-day assessment dated 12/29/22, Resident #19 was coded as being cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed a physician order dated 12/22/22 for "Acetaminophen (1) Oral Tablet 500 MG (milligram) Give 1 tablet by mouth every 6 hours as needed for mild to moderate pain..."

A review of the clinical record revealed a physician order's dated 12/22/22 for "Tramadol (2) Oral Tablet 50 MG Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain..."

A review of the eMAR (electronic medication administration record) for December 2022 and January 2023 revealed the following:

The resident received the as-needed acetaminophen on 12/22/22, twice on 12/23/22, 12/24/22 & 12/25/22, twice on 12/26/22, 12/27/22, twice on 12/29/22, 12/30/22 & 1/1/23, twice on 1/2/23, twice on 1/3/23.

The resident received the Tramadol on 12/27/22, 12/28/22, 12/31/22, 1/1/23, 1/4/23, 1/5/23, 1/6/23, 1/8/23, 1/9/23, and twice on 1/10/23.

A review of the progress notes for failed to reveal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

(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 697	Continued From page 26	F 697		

any evidence of documentation of non-pharmacological interventions being attempted or offered prior to the administration of the as-needed pain medication for each above administration.

A review of the comprehensive care plan revealed one dated 12/23/22 for "The resident is on pain medication therapy Tramadol and Acetaminophen r/t (related to) infection of prosthetic right hip joint." This care plan did not include any interventions for utilizing non-pharmacological interventions prior to the use of as-needed pain medication.

On 1/12/2023 at 1:54 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated that when residents complained of pain they did a pain assessment first and then attempted non-pharmacological interventions like repositioning prior to administering pain medications. RN #2 stated that they would ask the resident to rate their pain or use the non-verbal scale if needed and administer the as needed medication when the non-pharmacological interventions were not effective. RN #2 stated that they documented the non-pharmacological interventions they attempted in the progress notes. RN #2 stated that if there were no progress notes to evidence the non-pharmacological interventions were attempted that it meant the nurse when straight to the pain medications, maybe because the residents pain was so intense. RN #2 stated that it was key to document what non-pharmacological interventions were used and their system had a process to allow them to enter the notes when administering medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 697	Continued From page 27	F 697		

The facility policy "Pain Management Program" dated 1/2019 documented in part, "...An effective pain management plan uses a multi-pronged approach. Pharmacologic therapy is a mainstay of treatment, but non-pharmacologic interventions are equally as important...Consider using multiple nondrug therapies to better meet resident's individual needs. All interventions are evaluated and documented in the same way as medication therapy. The licensed nurse and other members of the interdisciplinary team observe and evaluate interventions and their effectiveness in relieving the resident's pain. The resident's response is documented and the licensed nurse discusses the interventions and their effectiveness with the healthcare provider and they collaborate with the resident and legal representative to develop additional interventions and make revisions to the resident's pain management plan..."

On 1/12/23 at approximately 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.

References:

1. Acetaminophen is used to relieve mild to moderate pain.
Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

2. Tramadol is used to relieve moderate to moderately severe pain.
Information obtained from https://medlineplus.gov/druginfo/meds/a695011.ht

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 697	Continued From page 28	F 697		
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F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to complete annual performance evaluations for two of five CNA (certified nursing assistant) employee records reviewed, CNAs #2 and #3. The findings include: For CNA #2, no performance review had been completed since her hire date of 7/21/22. For CNA #3, no performance review had been completed since 7/13/21. Five CNA employee records were reviewed to determine compliance with the requirement for annual performance reviews. When the facility provided the requested documents, CNA #2's record contained no evidence of any performance reviews since her hire date of 7/21/22. CNA #3's record contained no evidence of a performance review since 7/13/21. On 1/22/23 at 10:08 a.m., ASM (administrative staff member) #1, the administrator, stated she	F 730	**F730** 1. **With respect to the specific observation cited:** An annual performance review was completed for CNA #2 on 1/22/23. An annual performance review was also completed for CNA #3 on 1/22/23. 2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** An audit of current CNA HR files was conducted on 1/27/23 by the Executive Director to identify any other staff who have not had a performance review in the last 12 months. One additional CNA was identified who is currently on leave of absence. Performance review will be completed upon her return to work. 3. **With respect to what systemic measures have been put in place to address the stated concern:** HR manager or designee will audit SNF CNA files and provide monthly updates to SNA and DON on due dates for CNA performance evaluations. 4. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings of the employee file audits will be reviewed at Quality Assurance/Performance	

	Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director and/or Administrator are responsible for confirming implementation and ongoing compliance with the components of this action Plan of Correction, addressing and resolving variances that may occur. 5. **Areas cited in F730 will be corrected by 2/23/23.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 730	Continued From page 29 was currently responsible for completing staff performance evaluations. When asked about CNA #2, she stated, "It is in progress. I have started on it." When asked about CNA #3, she stated, "His is due. I have not gotten a chance to start on it." ASM #1 acknowledged that the performance reviews are due annually. No further information was provided prior to exit.	F 730		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732	**F732** 1. **With respect to the specific observation cited:** Nurse Staff information was posted immediately upon being notified during survey period. 2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** There is no other place in the facility where the staffing is posted. Executive Director trained the Administrator on requirement for posting staffing daily. 3. **With respect to what systemic measures have been put in place to address the stated concern:** The Administrator and/or Director of Nursing will conduct random observations twice weekly to verify the correct nurse staffing information is posted. 4. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings from the daily staffing posting observations will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. At the conclusion of the three-month period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring	

	implementation and ongoing compliance with the components of this Plan of Correction and addressing along with resolving variances that may occur. 5. **Areas cited for F732 will be corrected by 2/22/23.**	

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	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

(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 732	Continued From page 30 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to post the required nursing staffing information each shift for 30 of 30 days of records reviewed. The findings include: The facility's posted staffing information between 12/11/22 and 1/10/23 failed to include the total number of hours scheduled each shift for RNs (registered nurses), LPNs (licensed practical nurses), and CNAs (certified nursing assistants). The posted staffing failed to designate which nurses were RNs and which nurses were LPNs. On 1/10/23 at 11:20 a.m., the daily staffing sheet was posted on a desk in the center of the unit. The staffing sheet was dated 1/10/23, and listed the names of CNAs and nurses. However, the posting was contained in a complicated chart format. The posting did not differentiate between RNs and LPNs, and it did not include the total number of scheduled hours for each type of clinical staff member for each shift. The facility staff provided the staff postings for the 30 days prior to 1/10/23. The staff postings from	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 732	Continued From page 31 12/11/22 through 1/9/23 were in exactly the same format as the staff posting described above for 1/10/23. On 1/12/23 at 10:08 a.m., ASM (administrative staff member) #1, the administrator, was informed of this concern. She stated she is serving as the current staffing coordinator. After reviewing the staff posting for 1/10/23, ASM stated she believed the posting was "both easy and hard" to understand. She stated she agreed that it would be difficult for a resident or visitor to understand the information contained on the posting. She stated the nursing staff information did not differentiate between RNs and LPNs. She stated it would be difficult to determine which nurse was in charge on any particular shift. No further information was provided prior to exit. Complaint deficiency.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755	**F755** 1. **With respect to what systemic measures have been put in place to address the stated concern:** Lidocaine gel was obtained for resident #174 during survey on 1/12/23. 2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** A MAR-to-Cart audit was conducted by MDS on 1/12/23 to verify that all ordered medications were available for administration. If ordered medications were not found in-house, they were obtained from the pharmacy 3. **With respect to what systemic measures have been put in place to address the stated concern:** On 1/26/23, refresher training was conducted by the Director of	

Nursing regarding protocol when a medication is not available for administration. The Director of Nursing or her designee will audit medications pending delivery 3x/week for 1 month then 2x/week for the next 2 months.

4. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings from medication audits will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. At the conclusion of the three-month period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing along with resolving variances that may occur.
5. **Areas cited in F755 will be corrected by 2/22/23.**

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	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 755	Continued From page 32	F 755		

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to ensure a medication was available for one of six residents in the medication administration task; Resident #174.

The findings include:

For Resident #174, the facility staff failed to ensure the physician ordered medication, Lidocaine gel (1), was available for use.

A review of the physician's orders revealed one dated 1/9/23, to start on 1/10/23, for Lidocaine external gel 4%, apply to left buttock topically in the morning for pain, and remove per schedule.

On 1/11/23 at 9:21 AM, RN #2 (Registered Nurse) was observed to prepare and administer medications to Resident #174. RN #2 was

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F 755	Continued From page 33 unable to locate the Lidocaine gel for Resident #174 in the medication cart. A review of the nurse's notes revealed one dated 1/11/23 that documented in relation to the lidocaine, "Pharmacy contacted and reminded to deliver lidocaine patch. Second reminder pending." A nurse's note from the day before, 1/10/23, documented in relation to the lidocaine, "new admission, medication pending, MD (medical doctor) made aware." A review of the January 2023 MAR (Medication Administration Record) also revealed that the resident did not get this medication on 1/10/23 and 1/11/23. On 1/11/23 at 5:18 PM an interview was conducted with RN #2. She stated that the medication was ordered when the resident was admitted and that pharmacy was notified and reminded twice and it still had not arrived and she did not know why A review of the facility policy, "Community Medication Oversight Program" documented on page 4, "... The dashboard is reviewed each shift to ensure medications are available, administered and documented ... " On 1/12/23 at approximately 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.	F 755		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 755	Continued From page 34 References: Lidocaine belongs to the family of medicines called local anesthetics. This medicine prevents pain by blocking the signals at the nerve endings in the skin. https://www.mayoclinic.org/drugs-supplements/lidocaine-topical-application-route/proper-use/drg-20072776?p=1	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to	F 756	**F756** 1. **With respect to the specific observation cited:** Items #2 and #3 on the 12/23/22 consultant pharmacist review were addressed by the physician on 1/13/23. The resident had no adverse outcomes as a result of the delayed response. 2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** Consultant pharmacist reviews received in the last 30 days for residents currently in-house were audited by DNS on 1/30/23 to verify that recommendations were addressed by the physician. Any outstanding recommendations were addressed by the physician. 3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training was provided to nursing staff on 1/26/23 by MDS regarding the protocol for addressing consultant pharmacist recommendations. The Director of Nursing, or her designee, will audit consultant pharmacist	

	recommendations monthly for 3 months to verify the recommendations were addressed by the physician. 4. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings from monthly consultant pharmacists recommendation audits will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. At the conclusion of the three-month period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing along with resolving variances that may occur. 5. **Area cited in F756 will be corrected by 2/22/23.**	

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F 756	Continued From page 35 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to act upon pharmacy recommendations in a timely manner for one of 17 residents in the survey sample; Resident #19. The findings include: For Resident #19, a monthly pharmacy review was conducted on 12/23/22. The review documented in all capital letters at the top, "****CLINICALLY URGENT RECOMMENDATION. PROMPT RESPONSE REQUESTED.****" As of the survey, on 1/12/23, 2 of the 3 items identified on the review had not been addressed. On the most recent MDS (Minimum Data Set), an admission / 5-day assessment dated 12/29/22, Resident #19 was coded as being cognitively intact in ability to make daily life decisions. A review of the clinical record revealed a pharmacy note dated 12/23/22 that documented, "See report for any noted irregularities and/or recommendations."	F 756		

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F 756	Continued From page 36	F 756		

A review of the pharmacy's report, dated 12/23/22 documented at the top, "***CLINICALLY URGENT RECOMMENDATION. PROMPT RESPONSE REQUESTED.***" This report identified 3 items to be addressed, as follows:

1. "Directions for use (Medication): discharge order: brimonidine (1) 0/15% 1 drop both eyes twice daily; current order: brimonidine-dorzolamide 0.15-2% 1 drop both eyes twice daily."
2. "discharge order: polyvinyl-povidone (2) 1.4-0.6% 1 drop four times daily PRN; current order: polyvinyl-povidone 1/4-0.6% 1 drop every 4 hours PRN."
3. "Vancomycin (3) 750 film??"

A review of the physician's orders revealed that the first item identified on the above pharmacy report had been addressed/corrected immediately. Items #2 and #3 were still unchanged and not addressed as of the survey on 1/12/23.

On 1/12/23 at 12:44 PM, an interview was conducted with RN (Registered Nurse) #1. She stated that the recommendations were not addressed but should have been, given the pharmacy statement of the recommendations being clinically urgent.

A review of the facility policy, "9. Medication Regimen Review" documented, "When the Consultant Pharmacist identifies an urgent medication irregularity during MRR that requires immediate action, the consultant pharmacist will notify the nurse and request the facility contact the attending physician to communicate the issue

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F 756	Continued From page 37 and obtain direction or new orders. 9.1 If the attending physician has not responded by the time the consultant pharmacist has completed his/her consultation for the day, the issue will be escalated to the Medical Director for immediate action." On 1/12/23 at approximately 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. References: 1. Brimonidine is used to lower pressure in the eyes for patients with glaucoma. Information obtained from https://medlineplus.gov/druginfo/meds/a601232.html 2. polyvinyl-povidone is used to relieve dry, irritated eyes. Information obtained from https://www.webmd.com/drugs/2/drug-60574/polyvinyl-alcohol-w-povidone-ophthalmic-eye/details 3. Vancomycin is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a604038.html	F 756		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812	F812	

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F 812	Continued From page 38 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and in the course of a complaint investigation, the facility staff failed to prepare, store, and serve food in a sanitary manner in one of one facility kitchen, and in one of one activity room refrigerator. The findings include: On 1/10/23 at 12:01 p.m., a food transportation cart was checked for cleanliness in the facility's main kitchen. The inside of the cart contained loose black debris on the bottom, and multiple patches of sticky material on the top and sides. Several shelves of prepared food, including vegetables and desserts, were inside the cart. OSM (other staff member) #3, the dietary manager looked inside the cart, and stated: "It needs to be cleaned out, for sure." OSM #3 wore a hairnet that only partially covered her loose hair. Her bangs and loose hair stuck out from under	F 812	1. **With respect to the specific observation cited:** The food transportation cart was cleaned at the time of the survey. The vegetables and block of cheese in the walk-in refrigerator were covered and dated at the time of the survey. The dietary manager adjusted her hair restraint to contain her hair at the time of survey. The wet nested pans were re-washed and air dried at the time of the survey. The water in the sanitizer sink was changed, test strips were obtained, and the ratio of sanitizer was re-tested at the time of the survey. The activity room refrigerator was cleaned and unlabeled food was discarded at the time of the survey. Food transportation carts were deep cleaned on 1/12/23 by the kitchen team. Refrigerators in the main kitchen, activity room, and satellite kitchens were checked for uncovered food items and cleanliness by the RD on 1/12/23; no issues were identified. Observation rounds were conducted in the main kitchen on 1/12/23 by Administrator to verify that hair restraints were worn properly. No issues were identified. Pans in storage were checked for wet nesting by RD on 1/12/23. Pans found to be wet were re-washed and air dried. Additional supplies of sanitizer test strips were obtained and stored in the kitchen in a marked container in the Chef's office. No residents were affected	

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** All residents have the potential to be affected by the deficient practices.

3. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** Food transportation carts were deep cleaned on 1/12/23 by the kitchen team. Refrigerators in the main kitchen, activity room, and satellite kitchens were checked for uncovered food items and cleanliness by the RD on 1/12/23; no issues were identified. Observation rounds were conducted in the main kitchen on 1/12/23 by Administrator to verify that hair restraints were worn properly. No issues were identified. Pans in storage were checked for wet nesting by RD on 1/12/23. Pans found to be wet were re-washed and air dried. Additional supplies of sanitizer test strips were obtained and stored in the kitchen in a marked container in the Chef's office.

4. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training will be conducted on 1/31/23 with kitchen and dietary staff by the Registered Dietician and Dietary Manager regarding maintenance of food carts, safe food storage, proper use of hair restraints, wet nesting of pans, and sanitizer levels. Audits will be conducted weekly for the next three months by the Executive Chef or his designee to verify that food carts and refrigerators are clean, food items are covered and labeled, hair restraints are worn appropriately, pans in storage are not wet-nested, and sanitizer sinks are at correct concentrations.

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F 812	Continued From page 39 the net, exposing it to food being prepared in the kitchen. In the walk-in refrigerator, a tray of bite size, roasted mixed vegetable had been left uncovered to cool. Also, a large block of cheese was opened and partially unwrapped, and had been left without a date. OSM #3 stated the vegetables should have been covered, and the cheese should have been fully rewrapped and dated. Several steam table trays were stacked on a storage rack. OSM #3 separated three of the trays, and all of the trays were wet, indicating wet nesting. OSM #3 also separated approximately 10 sheet pans which were stacked on top of each other on the storage rack. These pans also were wet, indicating wet nesting. OSM #3 stated these would need to be rewashed, and stacked on their sides to allow for air drying, and to prevent wet nesting. OSM #4, a sous chef, stood near the three compartment sink. The third compartment contained five knives, a serving spoon, and a vegetable peeler. The water in this compartment contained a greasy film and black debris on the surface. When asked to test the water for the ratio of sanitizer, OSM #4 and OSM #3 were unable to locate a test strip. OSM #3 stated the test strips were in the main chef's jacket pocket, and the chef's jacket was in his locker. This chef was not in the building on this day. OSM #4 stated the water needed to be changed out because it was dirty. On 1/12/23 at 9:04 a.m., ASM (administrative staff member) #2, the director of nursing was asked to look inside the refrigerator in the activity	F 812	5. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings from weekly kitchen audits will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. At the conclusion of the three-month period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing along with resolving variances that may occur. 6. **Areas cited in F812 will be corrected by 2/23/23.**	

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F 812	Continued From page 40 room. She verified this refrigerator was the one used by residents who needed to keep food cold. A sticky substance covered part of the bottom shelf of the refrigerator. The refrigerator contained three containers of partially-eaten desserts. None of these containers was labeled or dated. ASM #2 stated the desserts should have been thrown out, and the refrigerator needed "a good cleaning." OSM #3 was unavailable for interview on 1/12/23. On 1/12/23 at 12:28 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. A review of the facility policy, "Food Storage, Preparation, and Storage," revealed, in part: "A food storage area includes walk-in and reach in refrigerators and freezers, under counter refrigeration and freezer units, bistro and common area refrigeration and freezer units, and any dry storage units...Food is prepared on clean, sanitized surfaces with clean, sanitized equipment and tools. Appropriate precautions are taken to prevent cross-contamination during production...Keeping your hair covered reduces the risk you will contaminate your hands by touching your hair. Also, federal and state regulations require all employees to wear hats or hairnets when preparing food." No further information was provided prior to exit.	F 812		
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her	F 847	**F847** 1. **With respect to the specific observation cited:** The community will review the admission agreement of each resident and identify which residents have been affected by the practice identified by the surveyor as deficient. Any residents whose admission	

agreement contains language requiring the resident to submit disputes to arbitration will be offered a new admission agreement that does not contain such requirement. Further, when a prospective resident receives an admission agreement, the community will explain that the admission agreement does not prevent any resident from seeking a remedy in a court when there is a dispute.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** All residents have the potential to be affected by this deficient practice.
3. **With respect to what systemic measures have been put in place to address the stated concern:** The Executive Director or her designee will verify that the correct version of the admission agreement that includes the appropriate Dispute Resolution language is being used upon signing of the admission agreement for each resident. If the appropriate Dispute Resolution language is not present in the admission agreement, a new admission agreement with the appropriate Dispute Resolution language will be executed for the resident.
4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the monthly admission agreement audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary

	action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required. 5. **Areas cited in F847 will be corrected by 2/22/23.**	

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F 847	Continued From page 41 representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the	F 847		

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	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 847	Continued From page 42	F 847		

resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and resident interview, it was determined that the facility staff failed to comply with all the requirements of a binding arbitration agreement for two of 17 residents in the survey sample; Residents #1 and #19.

The findings include:

1. For Resident #1, the facility staff failed to ensure the binding arbitration agreement the resident signed at the time of the most recent admission (2/26/20) met all the requirements by law.

On the most recent MDS (Minimum Data Set), a quarterly assessment dated 11/12/22, Resident #1 was coded as being cognitively intact in ability to make daily life decisions. Resident #1 was coded as requiring supervision for eating and limited assistance for locomotion and hygiene; and extensive assistance to total care for all other areas of activities of daily living.

A review of the resident's admission agreement was conducted and the following was revealed:

"VII. DISPUTE RESOLUTION

A. Grievance Policy: The Nursing Facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 847	Continued From page 43	F 847		

Resident Grievance Policy is available upon request and includes components required by applicable law. Contacts for all pertinent State regulatory and informational agencies and resident advocacy groups are listed in Exhibit 12.

B. Waiver of Trial by Jury. While most issues can be resolved under the Grievance Policy, in the event that the parties are unable to resolve their differences short of litigation, the parties agree that any trial shall be before a judge and not a jury. Accordingly:

WAIVER OF TRIAL BY JURY: THE PARTIES TO THIS AGREEMENT HEREBY KNOWINGLY AND UNCONDITIONALLY WAIVE ALL RIGHTS TO A TRIAL BY JURY IN ANY LAWSUIT OR COUNTERCLAIM THAT MAY BE FILED BY EITHER PARTY IN CONTRACT, TORT, EQUITY OR BY STATUTE ARISING OUT OF OR RELATED TO THIS AGREEMENT AND/OR ANY SERVICES OR CARE PROVIDED BY THE COMMUNITY TO THE RESIDENT. THIS WAIVER MEANS THAT IF ANY LAWSUIT IS BROUGHT, A JUDGE OF THE COURT AND NOT A JURY WILL DECIDE THE FACTS AND DETERMINE THE OUTCOME OF THE CASE. THE "COMMUNITY" SHALL INCLUDE THE MANAGER, OWNER AND/OR TENANT, AND ALL OF THEIR RESPECTIVE AFFILIATES, SUBSIDIARIES, PARENT COMPANIES AND SISTER COMPANIES AND ALL OF THEIR RESPECTIVE EMPLOYEES, AGENTS, CONTRACTORS, ASSIGNEES, OFFICERS AND DIRECTORS. THE UNDERSIGNED HAS HAD AN OPPORTUNITY TO REVIEW THIS PROVISION AND HAVE IT REVIEWED BY COUNSEL OF HIS/HER CHOICE. IF THE UNDERSIGNED IS ANYONE OTHER THAN

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(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 847	Continued From page 44 THE RESIDENT, THE UNDERSIGNED WARRANTS AND REPRESENTS THAT HE/SHE HAS FULL LEGAL AND EXPRESS AUTHORITY TO WAIVE THE RESIDENT'S AND THE RESIDENT'S HEIRS', BENEFICIARIES' AND/OR ESTATE'S RIGHT TO A TRIAL BY JURY. I HAVE READ AND UNDERSTAND THE FOREGOING AND VOLUNTARILY AGREE TO ITS TERMS." The above form was dated 09-2018. The above document did not contain all the legally required, clearly identified language, including the requirements that: 1. The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. 2. The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. 3. The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.	F 847		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 847	Continued From page 45	F 847		

In addition to the above missing, clearly explicit statements as required, an interview was conducted on 1/11/23 at 4:37 PM, with OSM #2 (Other Staff Member) the Admissions Director. She stated that she "presses" for residents to sign the above agreement, per her training that everyone is to sign the admission contract within 72 hours of admission. She stated that "They are not required to sign it but I require them to sign it."

On 1/12/23 at 11:30 AM, an interview was conducted with Resident #1. They were shown the agreement and stated that they understood it and was ok with it. However, they were not provided with an agreement that contained the current legally required language and statements, including items 1-3 above, as was required by law the date Resident #1 was readmitted.

On 1/12/23 at approximately 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. The arbitration agreement policy was requested from ASM #1, however none was provided prior to exit.

2. For Resident #19, the facility staff failed to ensure the binding arbitration agreement the resident signed at the time of admission (12/22/22) met all the requirements by law.

On the most recent MDS (Minimum Data Set), an admission / 5-day assessment dated 12/29/22, Resident #19 was coded as being cognitively intact in ability to make daily life decisions. Resident #19 was coded as requiring supervision for eating and limited to extensive care for all other areas of activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 847	Continued From page 46	F 847		

A review of the resident's admission agreement was conducted and the following was revealed:

"VII. DISPUTE RESOLUTION

A. Grievance Policy: The Nursing Facility's Resident Grievance Policy is available upon request and includes components required by applicable law. Contacts for all pertinent State regulatory and informational agencies and resident advocacy groups are listed in Exhibit 12.

B. Waiver of Trial by Jury. While most issues can be resolved under the Grievance Policy, in the event that the parties are unable to resolve their differences short of litigation, the parties agree that any trial shall be before a judge and not a jury. Accordingly:

WAIVER OF TRIAL BY JURY: THE PARTIES TO THIS AGREEMENT HEREBY KNOWINGLY AND UNCONDITIONALLY WAIVE ALL RIGHTS TO A TRIAL BY JURY IN ANY LAWSUIT OR COUNTERCLAIM THAT MAY BE FILED BY EITHER PARTY IN CONTRACT, TORT, EQUITY OR BY STATUTE ARISING OUT OF OR RELATED TO THIS AGREEMENT AND/OR ANY SERVICES OR CARE PROVIDED BY THE COMMUNITY TO THE RESIDENT. THIS WAIVER MEANS THAT IF ANY LAWSUIT IS BROUGHT, A JUDGE OF THE COURT AND NOT A JURY WILL DECIDE THE FACTS AND DETERMINE THE OUTCOME OF THE CASE. THE "COMMUNITY" SHALL INCLUDE THE MANAGER, OWNER AND/OR TENANT, AND ALL OF THEIR RESPECTIVE AFFILIATES, SUBSIDIARIES, PARENT COMPANIES AND SISTER COMPANIES AND ALL OF THEIR RESPECTIVE EMPLOYEES, AGENTS,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 847	Continued From page 47	F 847		

CONTRACTORS, ASSIGNEES, OFFICERS AND DIRECTORS. THE UNDERSIGNED HAS HAD AN OPPORTUNITY TO REVIEW THIS PROVISION AND HAVE IT REVIEWED BY COUNSEL OF HIS/HER CHOICE. IF THE UNDERSIGNED IS ANYONE OTHER THAN THE RESIDENT, THE UNDERSIGNED WARRANTS AND REPRESENTS THAT HE/SHE HAS FULL LEGAL AND EXPRESS AUTHORITY TO WAIVE THE RESIDENT'S AND THE RESIDENT'S HEIRS', BENEFICIARIES' AND/OR ESTATE'S RIGHT TO A TRIAL BY JURY.

I HAVE READ AND UNDERSTAND THE FOREGOING AND VOLUNTARILY AGREE TO ITS TERMS."

The above form was dated 09-2018.

The above document did not contain all the legally required, clearly identified language, including the requirements that:

1. The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.

2. The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

3. The agreement must explicitly state that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 847	Continued From page 48 neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. In addition to the above missing, clearly explicit statements as required, an interview was conducted on 1/11/23 at 4:37 PM, with OSM #2 (Other Staff Member) the Admissions Director. She stated that she "presses" for residents to sign the above agreement, per her training that everyone is to sign the admission contract within 72 hours of admission. She stated that "They are not required to sign it but I require them to sign it." On 1/12/23 at 11:30 AM, an interview was conducted with Resident #19. They were shown the agreement and stated that they understood it and was ok with it. However, they were not provided with an agreement that contained the current legally required language and statements, including items 1-3 above, as was required by law the date Resident #19 was admitted. On 1/12/23 at approximately 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. The arbitration agreement policy was requested from ASM #1, however none was provided prior to exit.	F 847		
F 848 SS=D	Binding Arbitration Agreements CFR(s): 483.70(n)(2)(iii)(iv)(6) §483.70(n)(2) The facility must ensure that: (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and	F 848	**F848** **With respect to the specific observation cited:** The community will review the admission agreement of each resident and identify which residents have been affected by the practice identified by the surveyor as deficient. Any residents whose admission	

agreement contains language requiring the resident to submit disputes to arbitration will be offered a new admission agreement that does not contain such requirement. Further, when a prospective resident receives an admission agreement, the community will explain that the admission agreement does not prevent any resident from seeking a remedy in a court when there is a dispute.

2.**With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** All residents have the potential to be affected by this deficient practice.

3.**With respect to what systemic measures have been put in place to address the stated concern:** The Executive Director or her designee will verify that the correct version of the admission agreement that includes the appropriate Dispute Resolution language is being used upon signing of the admission agreement for each resident. If the appropriate Dispute Resolution language is not present in the admission agreement, a new admission agreement with the appropriate Dispute Resolution language will be executed for the resident.

4.**With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the monthly admission agreement audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is

	reviewed and discussed at QAPI meetings and action initiated if required. 5.**Areas cited in F848 will be corrected by 2/22/23.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 848	Continued From page 49 (iv) The agreement provides for the selection of a venue that is convenient to both parties. §483.70(n)((6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and resident interview, it was determined that the facility staff failed to ensure the binding arbitration agreements contained explicit language for the selection of an arbitrator and venue, for two of 17 residents in the survey sample; Residents #1 and #19. The findings include: 1. For Resident #1, the facility staff failed to ensure the binding arbitration agreement the resident signed at the time of the most recent admission (2/26/20) met all the requirements by law. On the most recent MDS (Minimum Data Set), a quarterly assessment dated 11/12/22, Resident #1 was coded as being cognitively intact in ability to make daily life decisions. During a review of the resident's admission agreement, the following document was reviewed: "VII. DISPUTE RESOLUTION	F 848		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 848	Continued From page 50	F 848		

A. Grievance Policy: The Nursing Facility's Resident Grievance Policy is available upon request and includes components required by applicable law. Contacts for all pertinent State regulatory and informational agencies and resident advocacy groups are listed in Exhibit 12.

B. Waiver of Trial by Jury. While most issues can be resolved under the Grievance Policy, in the event that the parties are unable to resolve their differences short of litigation, the parties agree that any trial shall be before a judge and not a jury. Accordingly:

WAIVER OF TRIAL BY JURY: THE PARTIES TO THIS AGREEMENT HEREBY KNOWINGLY AND UNCONDITIONALLY WAIVE ALL RIGHTS TO A TRIAL BY JURY IN ANY LAWSUIT OR COUNTERCLAIM THAT MAY BE FILED BY EITHER PARTY IN CONTRACT, TORT, EQUITY OR BY STATUTE ARISING OUT OF OR RELATED TO THIS AGREEMENT AND/OR ANY SERVICES OR CARE PROVIDED BY THE COMMUNITY TO THE RESIDENT. THIS WAIVER MEANS THAT IF ANY LAWSUIT IS BROUGHT, A JUDGE OF THE COURT AND NOT A JURY WILL DECIDE THE FACTS AND DETERMINE THE OUTCOME OF THE CASE. THE "COMMUNITY" SHALL INCLUDE THE MANAGER, OWNER AND/OR TENANT, AND ALL OF THEIR RESPECTIVE AFFILIATES, SUBSIDIARIES, PARENT COMPANIES AND SISTER COMPANIES AND ALL OF THEIR RESPECTIVE EMPLOYEES, AGENTS, CONTRACTORS, ASSIGNEES, OFFICERS AND DIRECTORS. THE UNDERSIGNED HAS HAD AN OPPORTUNITY TO REVIEW THIS PROVISION AND HAVE IT REVIEWED BY COUNSEL OF HIS/HER CHOICE. IF THE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 848	Continued From page 51	F 848		

UNDERSIGNED IS ANYONE OTHER THAN THE RESIDENT, THE UNDERSIGNED WARRANTS AND REPRESENTS THAT HE/SHE HAS FULL LEGAL AND EXPRESS AUTHORITY TO WAIVE THE RESIDENT'S AND THE RESIDENT'S HEIRS', BENEFICIARIES' AND/OR ESTATE'S RIGHT TO A TRIAL BY JURY.

I HAVE READ AND UNDERSTAND THE FOREGOING AND VOLUNTARILY AGREE TO ITS TERMS."

The above form was dated 09-2018.

The above document did not contain all the legally required, clearly identified language, including the requirements that the agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and the agreement provides for the selection of a venue that is convenient to both parties.

In addition to the above missing, clearly explicit statement as required, an interview was conducted on 1/11/23 at 4:37 PM, with OSM #2 (Other Staff Member) the Admissions Director. She stated that she "presses" for residents to sign the above agreement, per her training that everyone is to sign the admission contract within 72 hours of admission. She stated that "They are not required to sign it but I require them to sign it."

On 1/12/23 at 11:30 AM, an interview was conducted with Resident #1. They were shown the agreement and stated that they understood it and was ok with it. However, they were not provided with an agreement that contained the current legally required language and statements, including above identified requirement, as was

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F 848	Continued From page 52	F 848		

required by law the date Resident #1 was readmitted.

On 1/12/23 at approximately 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. An arbitration agreements policy was requested from ASM #1, however none was provided prior to exit.

2. For Resident #19, the facility staff failed to ensure the binding arbitration agreement the resident signed at the time of admission (12/22/22) met all the requirements by law.

On the most recent MDS (Minimum Data Set), an admission / 5-day assessment dated 12/29/22, Resident #19 was coded as being cognitively intact in ability to make daily life decisions.

During a review of the resident's admission agreement, the following document was reviewed:

"VII. DISPUTE RESOLUTION

A. Grievance Policy: The Nursing Facility's Resident Grievance Policy is available upon request and includes components required by applicable law. Contacts for all pertinent State regulatory and informational agencies and resident advocacy groups are listed in Exhibit 12.

B. Waiver of Trial by Jury. While most issues can be resolved under the Grievance Policy, in the event that the parties are unable to resolve their differences short of litigation, the parties agree that any trial shall be before a judge and not a jury. Accordingly:

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	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 848	Continued From page 53	F 848		

WAIVER OF TRIAL BY JURY: THE PARTIES TO THIS AGREEMENT HEREBY KNOWINGLY AND UNCONDITIONALLY WAIVE ALL RIGHTS TO A TRIAL BY JURY IN ANY LAWSUIT OR COUNTERCLAIM THAT MAY BE FILED BY EITHER PARTY IN CONTRACT, TORT, EQUITY OR BY STATUTE ARISING OUT OF OR RELATED TO THIS AGREEMENT AND/OR ANY SERVICES OR CARE PROVIDED BY THE COMMUNITY TO THE RESIDENT. THIS WAIVER MEANS THAT IF ANY LAWSUIT IS BROUGHT, A JUDGE OF THE COURT AND NOT A JURY WILL DECIDE THE FACTS AND DETERMINE THE OUTCOME OF THE CASE. THE "COMMUNITY" SHALL INCLUDE THE MANAGER, OWNER AND/OR TENANT, AND ALL OF THEIR RESPECTIVE AFFILIATES, SUBSIDIARIES, PARENT COMPANIES AND SISTER COMPANIES AND ALL OF THEIR RESPECTIVE EMPLOYEES, AGENTS, CONTRACTORS, ASSIGNEES, OFFICERS AND DIRECTORS. THE UNDERSIGNED HAS HAD AN OPPORTUNITY TO REVIEW THIS PROVISION AND HAVE IT REVIEWED BY COUNSEL OF HIS/HER CHOICE. IF THE UNDERSIGNED IS ANYONE OTHER THAN THE RESIDENT, THE UNDERSIGNED WARRANTS AND REPRESENTS THAT HE/SHE HAS FULL LEGAL AND EXPRESS AUTHORITY TO WAIVE THE RESIDENT'S AND THE RESIDENT'S HEIRS', BENEFICIARIES' AND/OR ESTATE'S RIGHT TO A TRIAL BY JURY.

I HAVE READ AND UNDERSTAND THE FOREGOING AND VOLUNTARILY AGREE TO ITS TERMS."

The above form was dated 09-2018.

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	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 848	Continued From page 54 The above document did not contain all the legally required, clearly identified language, including the requirements that the agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and the agreement provides for the selection of a venue that is convenient to both parties. In addition to the above missing, clearly explicit statements as required, an interview was conducted on 1/11/23 at 4:37 PM, with OSM #2 (Other Staff Member) the Admissions Director. She stated that she "presses" for residents to sign the above agreement, per her training that everyone is to sign the admission contract within 72 hours of admission. She stated that "They are not required to sign it but I require them to sign it." On 1/12/23 at 11:30 AM, an interview was conducted with Resident #19. They were shown the agreement and stated that they understood it and was ok with it. However, they were not provided with an agreement that contained the current legally required language and statements, including above identified requirement, as was required by law the date Resident #1 was admitted. On 1/12/23 at approximately 2:30 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. An arbitration agreements policy was requested from ASM #1, however none was provided prior to exit.	F 848		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883	**F883** 1. **With respect to the specific observation cited:** The Pneumonia vaccination was administered to resident #10 on 1/11/23. 2. **With respect to how the facility**	

	will identify residents with the potential for the identified concern and take corrective action: The records of current residents were reviewed on 1/12/23 by MDS to verify that residents were offered the pneumococcal vaccine and it given if requested. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training was conducted on 1/26/23 with nursing staff by the Director of Nursing regarding the immunization/vaccination administration procedures. The Director of Nursing or designee will audit immunizations and consents weekly for one month, then bi-weekly for two months to ensure vaccinations are administered timely if requested. 3. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings from weekly vaccine audits will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. At the conclusion of the three-month period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing along with resolving variances that may occur. 4. **Areas cited in F883 will be corrected by 2/22/23.**	

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THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 883	Continued From page 55 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 883	Continued From page 56	F 883		

already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement a complete immunization program for one of five residents immunization record reviews, Resident #10.

The findings include:

1. For Resident #10 (R10), the facility staff failed to provide the pneumonia vaccination in a timely manner.

R10 was admitted to the facility on 9/1/2022. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/9/2022, the resident was assessed as being cognitively in making daily decisions. In Section O - Special Treatments, Programs and Procedures, the resident was coded as not being up to date on the pneumococcal vaccination and the vaccine not being offered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

(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 883	Continued From page 57	F 883		

Review of R10's clinical record failed to evidence documentation of a pneumococcal vaccine being administered or offered.

The "Admission Evaluation" for R10, dated 9/1/2022, documented the date unknown for pneumococcal vaccine.

On 1/11/2023 at approximately 9:00 a.m., a request was made to RN (registered nurse) #1, MDS coordinator/Infection Preventionist for evidence of pneumonia vaccination screening and offering for R10.

On 1/11/2023 at approximately 10:30 a.m., RN #1 provided a resident pneumococcal vaccination consent documenting verbal consent for the pneumococcal vaccine to be administered to R10 by the responsible party dated 11/10/2022. RN #1 stated that there were delays in getting the vaccine from pharmacy and they were only able to get the vaccine in last week so it had not been administered yet.

On 1/12/2023 at 1:10 p.m., an interview was conducted with RN #1. RN #1 stated that all residents were screened for immunizations on admission. RN #1 stated that if residents were eligible to receive the pneumococcal vaccine and consented to receive the vaccine they would order the vaccine from the pharmacy and administer it. RN #1 stated that there was a delay with the pharmacy getting the vaccine for R10 and it had come in last week. RN #1 stated that the night shift staff were responsible for reordering vaccines when needed and had reordered the pneumococcal vaccine but there was a delay. RN #1 stated that R10 should have received the pneumococcal vaccine and it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 883	Continued From page 58 reasonable for them to have it by now after consenting on 11/10/2022. RN #1 stated that they would check with the pharmacy to see if they were able to get evidence of the delay in getting the vaccine in the facility. On 1/12/2023 at 1:49 p.m., RN #1 stated that they had attempted to reach the pharmacy and did not have anything to provide regarding the delay in obtaining the vaccine from the pharmacy. The facility policy, "Influenza and Pneumococcal Immunizations" dated 7/11/22 documented in part, "...Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized..." The facility policy, "Infection Prevention and control program for skilled communities" dated 2018 documented in part, "...Upon move in, the resident's immunization status is evaluated and vaccination is offered if not previously vaccinated. Additionally, pneumococcal vaccination is offered yearly during influenza clinics..." On 1/12/2023 at 2:30 p.m., ASM (administrative staff member) #1, the administrator was made of the above concern. No further information was provided prior to exit.	F 883		
F 885 SS=C	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their	F 885	**F885** 1. **With respect to the specific observation cited:** Notification was sent by the Administrator on 1/30/23 to residents and responsible parties of residents who were in-house at the time of the new COVID cases informing them of	

the positive cases that occurred on 12/8/22 – 12/25/22.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** There were no new COVID cases identified at the SNF since 12/25/22.
3. **With respect to what systemic measures have been put in place to address the stated concern:** The Skilled Nursing Administrator was re-educated by the Executive Director on 1/26/23 regarding the requirement to inform residents and their responsible parties of new COVID cases identified by 5 p.m. the next calendar day. The Administrator will maintain a log of COVID cases identified, a copy of the notice provided to residents and their responsible parties, and the distribution list for each notice. This log will be audited monthly by the Executive Director or her designee to verify that notices are being provided as required.
4. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings from audits of COVID notices will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. At the conclusion of the three-month period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing along with resolving variances that may occur.
5. **Areas cited in F885 will be**

	corrected by 2/22/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 885	Continued From page 59 representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review it was determined the facility staff failed to evidence notification of facility COVID-19 activity to residents and/or responsible parties and families during active COVID-19 cases confirmed in the facility 12/8/2022-12/25/2022. The findings include: The facility staff failed to evidence notification of residents and responsible parties by 5:00 p.m. the next calendar day following confirmed resident infections of COVID-19 (1) on 12/8/2022, 12/11/2022, 12/19/2022 and 12/25/2022.	F 885		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 885	Continued From page 60 On 1/10/2023 at approximately 1:15 p.m., during entrance meeting with RN (registered nurse) #1, MDS coordinator/infection preventionist, RN #1 stated that residents/responsible parties and families were notified of COVID-19 activity in the building by the administrator. RN #1 stated that the facility had recently cleared an outbreak of COVID-19 that began in December of 2022. On 1/10/2023 at approximately 2:44 p.m., RN #1 provided a list of residents who were confirmed with COVID-19 over the past four weeks. The list documented seven resident names, two residents were confirmed positive on 12/8/2022, two on 12/11/2022, two on 12/19/2022 and one on 12/25/2022. On 1/11/2023 at approximately 9:00 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of notification of facility COVID-19 activity to residents and/or responsible parties and families during active COVID-19 cases confirmed in the facility 12/8/2022-12/25/2022. On 1/12/2023 at 11:22 a.m., ASM #1 provided an email chain copy dated 1/9/2023. When asked about the email chain, ASM #1 stated that it was not sent out to residents and/or responsible parties because it had room numbers in the attachment that were on isolation. ASM #1 stated that they did not send that email out and did things differently when they sent things to the families. ASM #1 stated that they had nothing to provide that was sent out during the confirmed resident COVID-19 cases. The facility policy, "COVID-19: Testing and Reporting (Residents & Team Members)" dated	F 885		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

(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 885	Continued From page 61 5/9/2022 documented in part, "...Outbreak is a new COVID-19 infection in any healthcare personnel or any nursing-home onset of COVID-19 infection in a resident..." The policy failed to evidence guidance on notification of residents and responsible parties by 5:00 p.m. the next calendar day following confirmed resident infections of COVID-19. On 1/12/2023 at approximately 2:30 p.m., ASM #1, the administrator was made aware of the above concern. No further information was presented prior to exit. Reference: (1) COVID-19 COVID-19 is caused by a coronavirus called SARS-CoV-2. Coronaviruses are a large family of viruses that are common in people and may different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people. This occurred with MERS-CoV and SARS-CoV, and now with the virus that causes COVID-19. The SARS-CoV-2 virus is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir. However, the exact source of this virus is unknown. This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads	F 885		
F 886 SS=C	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6)	F 886	**F886** 1. **With respect to the specific observation cited:** RN #3 was tested for COVID-19 at the time of the survey with a negative result. A round of staff testing for COVID-	

	19 was initiated 1/30/23 and will be completed by 1/31/23. 2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** All residents can potentially by the deficient practices. 3. **With respect to what systemic measures have been put in place to address the stated concern:** The Administrator and Director of Nursing were re-educated by the Human Resources Manager on 1/12/23 regarding staff testing requirements for COVID-19. If staff testing is required, the records of staff testing will be audited by HR manager or designee to verify that all necessary staff were tested. 4. **With respect to how the plan or corrective measures will be monitored:** Over the next three months, the findings from staff testing audits if conducted will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings. At the conclusion of the three-month period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing along with resolving variances that may occur. 5. **Areas cited for F886 will be corrected by 2/22/23.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 886	Continued From page 62	F 886		

§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:

§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not
limited to:
(i) Testing frequency;
(ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 886	Continued From page 63	F 886		

was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and facility document review it was determined the facility staff failed to evidence COVID-19 testing of staff during an outbreak of active COVID-19 cases confirmed in the facility 12/8/2022-12/25/2022 for one of 3 staff sampled, RN (registered nurse) #3.

The findings include:

The facility staff failed to evidence COVID-19 testing of staff following confirmed resident infections of COVID-19 (1) on 12/8/2022, 12/11/2022, 12/19/2022 and 12/25/2022.

On 1/10/2023 at approximately 1:15 p.m., during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

(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 886	Continued From page 64	F 886		

entrance meeting with RN (registered nurse) #1, MDS coordinator/infection preventionist, RN #1 stated that they did not have any active COVID-19 cases at that time with staff or residents. RN #1 stated that the last outbreak had began on 12/8/2022 with a positive resident and the last resident had tested positive on 12/25/2022. RN #1 stated that the administrator and human resources had handled any staff testing during that time and they were not aware of any staff cases.

On 1/10/2023 at approximately 2:44 p.m., RN #1 provided a list of residents who were confirmed with COVID-19 over the past four weeks. The list documented seven resident names, two residents were confirmed positive on 12/8/2022, two on 12/11/2022, two on 12/19/2022 and one resident on 12/25/2022. RN #1 also provided a resident vaccination roster documenting 100% resident COVID-19 primary series vaccination as well as a staff roster documenting 100% staff COVID-19 primary series vaccination.

On 1/11/2023 at approximately 3:00 p.m., a request was made to RN #1 for evidence of staff testing for a sample of three current staff members who worked on the skilled nursing unit.

On 1/11/2023 at 4:40 p.m., RN #1 provided documentation for two of the sampled staff evidencing positive test results showing that they were in the 90 day post infection testing window. RN #1 provided a negative COVID test dated 11/7/2022 for RN #3. RN #1 stated that they did not test any staff during the outbreak in December and they had guidance from their local health department they would provide documenting why they did not test any staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 886	Continued From page 65	F 886		

On 1/11/2023 at approximately 5:45 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of staff testing and/or contact tracing related to the identified positive resident COVID-19 cases in the facility 12/8/2022-12/25/2022.

On 1/12/2023 at 11:57 a.m., an interview was conducted with OSM (other staff member) #1, human resource manager. OSM #1 stated that human resources coordinated whole house testing when it was conducted. OSM #1 stated that when there were outbreaks in different sections of the facility, they were conducting their own tests and providing the test results to human resources at the end of the day. OSM #1 stated that they kept the results and validated any reasons why staff members may have missed their test. OSM #1 stated that the administrator was in charge of coordinating testing in December of 2022 because the director of nursing had left.

On 1/12/2023 at 2:21 p.m., an interview was conducted with ASM #1, administrator. ASM #1 stated that during December of 2022 they conducted contact tracing and testing for exposed residents but did not conduct any for staff. ASM #1 stated that having independent living and skilled nursing there were certain requirements for each unit. ASM #1 stated that when the county came in to visit they did not require contact tracing of staff. ASM #1 stated that they have been reporting cases to the local health department and working with them during the outbreak in December of 2022 but did not have any evidence of staff testing to provide.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

(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 886	Continued From page 66	F 886		

The facility policy, "COVID-19: Testing and Reporting (Residents & Team Members)" dated 5/9/2022 documented in part, "...Testing of Team Members and Residents in Response to an Outbreak 26. A new COVID-19 infection in any team member or any community onset COVID-19 infection in a resident will trigger an outbreak investigation ...27. Upon identification of a single new case of COVID-19 infection in any team member or residents, the SNA(skilled nursing administrator)/designee will begin testing. 28. Outbreak testing will be performed either through contact tracing or broad-based (e.g. community-wide) testing (see table above). 29. All team members and residents that test negative will be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among team members or residents for a period of at least 14 days since the most recent positive result .."

On 1/12/2023 at approximately 2:30 p.m., ASM #1, the administrator was made aware of the above concern.

No further information was presented prior to exit.

Reference:
(1) COVID-19
COVID-19 is caused by a coronavirus called SARS-CoV-2. Coronaviruses are a large family of viruses that are common in people and may different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people. This occurred with MERS-CoV and SARS-CoV, and now with the virus that causes COVID-19. The SARS-CoV-2 virus is a betacoronavirus, like MERS-CoV and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 886	Continued From page 67 SARS-CoV. All three of these viruses have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir. However, the exact source of this virus is unknown. This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads	F 886		