STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495312	A. BUILDING _____ B. WING _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON CNTR/FALCONS LANDING	20535 EARHART PLACE POTOMAC FALLS, VA 20165

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/2/23 through 5/4/23. 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 standard survey was conducted 05/02/2023 through 05/04/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 60 certified bed facility was 47 at the time of the survey. The survey sample consisted of 25 resident reviews and 31 staff reviews.	F 000		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must– (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services	F 582	F582 • Residents #25 and #27 continue to reside in the facility. The revised SNFABN form was provided to both residents.I • All residents who are Medicare beneficiaries have the potential to be affected. On 5/3/23, the form was corrected to ensure that no options were preselected.	06/09/2023

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

Director of Health Services 5/19/23.

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 582	Continued From page 1 specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review	F 582	Continued From page 1 F582 • The Social Worker was in-serviced by the Administrator on SNFABN requirements and affording the resident an opportunity to continue skilled care services by having Medicare make a determination of coverage. • The Administrator or designee will conduct compliance audits of SNFABN notices 3 times a week for 4 weeks. The results of these audits will be reviewed in the Quality Assurance Committee monthly meetings for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plans of correction as indicated.	06/09/2023

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F 582	Continued From page 2	F 582		

and facility documentation review, the facility staff pre-selected the option on the SNF ABN notice (Skilled Nursing Facility Advance Beneficiary Notice) issued to 2 Residents (Resident #25 and #27) in a survey sample of 3 Residents, reviewed for such notices.

The findings included:

On 5/3/23, the facility Administrator was asked to provide a listing of Residents who were discharged from Medicare Part A services. From this listing a sample was selected which consisted of Resident #25 and #27. The notices issued to these Residents were reviewed and revealed the following:

1. For Resident #25, the facility staff provided a SNFABN notice prior to skilled care services ending, and below the options box had typed in, "Additional information: I am choosing Option 3". Resident #25 was not afforded the opportunity to continue skilled care services and have Medicare make a determination about coverage of such services, as the facility had pre-selected/indicated the Resident chose option 3.

Review of the clinical record revealed that Resident #25 was readmitted to the facility on 12/21/22, for skilled care, Medicare part A services. When skilled services were scheduled to end on 1/25/23, the Resident remained in the facility. The facility staff issued a NOMNC (Notice of Medicare Non-Coverage) form on 1/23/23. The facility staff provided Resident #25 with the second required notice, a SNF ABN, which allows the resident an option to continue to receive services, be notified of the expected cost, and have Medicare make the coverage determination

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F 582	Continued From page 3 once a bill is submitted to Medicare. 2. For Resident #27, the facility staff provided a SNFABN notice prior to skilled care services ending, with option 3 noted/pre-filled in, therefore eliminating the Resident's opportunity to have Medicare make the coverage determination. Review of the clinical record for Resident #27's skilled care ended on 12/21/22, and the Resident remained in the facility for long-term care. 5/4/23 at approximately 10 AM, an interview was conducted with Employee G, the facility social worker. Employee G was asked to explain the NOMNC and ABN forms and explain when they are issued. Employee G stated, "For the ABN, if they stay long term care it is option 2. Option 3 is for people who don't want to stay here, and it is kind of irrelevant". Employee G had difficulty verbalizing what each of the 3 options on the ABN form represented and how that would affect the services provided to the Resident based on their selection. Employee G provided Surveyor C with a blank ABN form that is used by the facility. It was noted that under the 3 options for Residents to make a selection, it was pre-filled/typed with, "Additional information. I choose option 3". Employee G said, option 3, "Says you don't want our care and don't want to pay for it". Employee G also stated, "That was on the form I was given, and I don't touch that". The facility policy titled, "Advance Beneficiary Notice of Non-Coverage", was reviewed. This policy read, "... Blanks (G)-(I) must be completed	F 582		

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F 582	Continued From page 4 by the beneficiary when the ABN is issued and should not be pre-filled... The ABN may not be modified except as specifically allowed by these instructions. Notifiers must exercise caution before adding any customizations beyond these guidelines, since changing ABNs too much could result in invalid notice and healthcare provider or supplier liability for non-covered charges...". In the CMS document, "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)". This instruction sheet read, "...There are 3 options listed on the SNFABN with corresponding check boxes. The beneficiary must check only one option box. If the beneficiary is physically unable to make a selection, the SNF may enter the beneficiary's selection at his/her request and indicate on the notice that this was done for the beneficiary. Otherwise, SNFs are not permitted to select or pre-select an option for the beneficiary as this invalidates the notice...". Accessed online at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNF-ABN- On 5/4/23 at approximately 10:30 AM, the facility Administrator was made aware of the above findings. No further information was provided.	F 582		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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F 689	Continued From page 5 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to ensure the environment remained free of potential accident hazards (a portable heater) for one (Resident (R) 3) out of a survey sample of two. There was no evaluation of the resident's cognition, ambulatory status, and potential risks associated with the use of a portable heater completed prior to the use of the heater. Findings include: Review of a policy provided by the facility titled "Incidents & Accidents," dated 01/09/23 failed to address potential environmental or equipment hazards. Review of a document provided by the facility titled "Profile Face Sheet," indicated R3 was admitted to the facility on 01/29/20 with diagnoses that included generalized muscle weakness, difficulty walking, and dementia. Review of a document provided by the facility titled "Care Plan" dated 02/08/20 indicated R3 had impaired physical mobility and required assistance. In addition, the "Care Plan" indicated the resident had a decline in physical functioning due to weakness. The "Care Plan" dated 04/23/22, revealed the resident had impaired cognition related to memory impairment. Review of R3's quarterly "Minimum Data Set (MDS)" provided by the facility with an	F 689	F689 • Resident #3 continues to reside in the facility. The Heater was removed from the residents room on 5/4/2023. The resident was clinically assessed and no adeverse affects were noted. • All residents have the potential to be affected. On 5/5/2023, a facility wide audit was conducted to ensure the environment was free of potential accident hazards (portable heaters.) • The facility policy for incidents and accidents was amended to reflect the potential for environmental and/or equipment hazards. • The Maintenance Department will be in-serviced on the regulation for maintaining a facility that is free of accident hazards/supervision/devices.	06/09/2023

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F 689	Continued From page 6 Assessment Reference Date (ARD) of 04/14/23 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of 10 out of 15 which indicated the resident was moderately cognitively impaired. The assessment indicated the resident required limited assistance of one staff member for bed mobility and transfers. The assessment revealed the resident could ambulate in her room with limited assistance of one staff member. The assessment revealed the resident used a walker or a wheelchair for ambulation. Review of documents provided by the facility titled "Guardian Angel Rounding Tool" for R3, dated 04/03/23, 04/10/23, 04/17/23, and 04/21/23 indicated the resident's room was cluttered and the resident would refuse assistance from staff to clean and to pick up her personal items. During an observation and interview on 05/02/23 at 11:50 AM, R3 had a portable heater located in her room and across from the foot of her bed. The heater was on. There was no clutter around the portable heating device. The resident stated she had the heater for multiple years. The resident did not want to be interviewed further. During an observation on 05/02/23 at 4:33 PM, R3's door was open, and the portable heater was still present. During an interview on 05/03/23 at 9:34 AM, Certified Nursing Assistant (CNA) B confirmed R3 had a portable heater in her room and stated the resident has directed staff not to touch her personal items and stated the resident turns the heater on herself. During an interview on 05/03/23 at 9:27 AM,	F 689	Continued From page 6 F689 • The Maintenance Director and/or designee will conduct preventative maintenance rounds of all resident rooms/areas once weekly for 4 weeks to ensure the environment is free of hazards. The results of these audits will be reviewed in the Quality Assurance Committee monthly meetings for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plans of correction as indicated.	06/09/2023

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F 689	Continued From page 7	F 689		

Maintenance (Employee (Empl) D) confirmed there was a heater in R3's room and it was placed there when the heating went out. Empl D confirmed the facility purchased the heater. Empl D stated he did not check out the portable heater or monitor the heater after the heater was placed in the resident's room.

During an interview on 05/03/23 at 9:46 AM, the Facility Operations Director (Empl F) stated he was not aware there was a portable heater in R3's room. Empl F stated he would expect the portable heater to be checked and inspected. Empl F stated he did not work with nursing to identify residents who may be at an increased safety risk with the use of a portable heater.

During an interview on 05/03/23 at 10:15 AM, Empl D and Empl F both stated there were no other portable heaters in any resident rooms. Empl F stated there were no logs which would indicate which resident or residents who received a portable heater.

A request was made on 05/03/23 at 10:34 AM for a purchase invoice for the portable heaters from the Administrator. No document was provided prior to the end of the survey.

During an interview on 05/03/23 at 12:11 PM, the Facility's Maintenance/Housekeeping Director (Empl H) stated portable heaters were provided as long as they were used per manufacturer guidelines. Empl H stated the portable heaters had no heating elements and were tampered proof. Empl H stated there were no tags attached to the heaters which would indicate safety and inventory. Empl H stated he has not seen any data tracking on the heating devices which would

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F 689	Continued From page 8 indicate the date of purchase, date of installation, and date of inspection. During an interview on 05/03/23 at 12:54 PM, the Social Worker (Empl G) stated she entered R3's room on a daily basis to check on the resident. Empl G stated she remembered the resident with a portable heater and had reported this verbally to Empl D on a couple occasions. Empl G stated she was concerned about the safety of the heater in the resident's room. During an interview on 05/03/23 at 3:20 PM, the Medical Director (Empl K) stated R3's skin was fragile, had memory issues, and was at risk of falling. Empl K stated the resident did not comply with fall precautions and would not use her walker to assist her with ambulation. During an interview on 05/04/23 at 2:13 PM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON/Empl C) both confirmed there was no safety evaluation completed for R3 prior to the use of the portable heater. The DON stated the staff were responding to the lack of heat for the residents.	F 689		
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	F 732		

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F 732	Continued From page 9 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 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 documentation review, the facility staff failed to post daily staffing information for Residents, staff, and visitors to see, which has the potential to affect all Residents. The findings included: On 5/3/23 at approximately 11:00 AM, a facility tour was conducted to look for daily staffing	F 732	F732 • On 5/10/2023, the location of the staff posting was changed to ensure that the posting is always visible to the public. • The posting is now placed in an acrylic frame on the way outside of the nursing supervisor office. • The Staff Scheduler was educated on the regulation for "daily staff posting" and the importance of its visibility to the public for review. • The DON or designee will conduct audits 3 times weekly for 4 weeks for compliance of data availability. The results of these audits will be reviewed in the Quality Assurance Committee monthly meetings for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plans of correction as indicated.	06/09/2023

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F 732	Continued From page 10 posted. With the assistance of facility staff, the surveyor was taken to the unit manager office where on a table inside the office door, the daily staff posting was noted. The facility staff stated that the scheduler fills out the daily staffing and puts it in the office daily. On 5/5/23, during the mid-late morning, the Director of Nursing again confirmed that the daily staff posting is completed by the scheduler each day and placed in the unit manager office, which was vacant at the time of survey due to the unit manager position being vacant. The Director of Nursing (DON) further confirmed that the office is locked daily around 4:30-5:30 PM, therefore Residents and/or families have no access to the area in the evenings. A review of the facility policy titled, "Nurse Staffing Posting" was conducted. This policy read, "The nurse staffing sheet will be posted in the nurses' station... The facility must, upon oral or written request, make nurse staffing data available to the public for review". On 5/5/23, during an end of day meeting with the facility Administrator and DON, were made aware of the above findings. No further information was provided.	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	F 755		

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F 755	Continued From page 11 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. §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, interview, clinical record review and facility documentation the facility staff failed to provide pharmaceutical services including procedures that assure accurate acquiring and dispensing of medications, for 1 Resident, (#95) in a survey sample of 25 Residents. The findings included: For Resident # 95 the facility staff failed to secure	F 755	F755 • Resident #95 continues to reside in the facility. The hard scripts were removed from the residents chart on 5/3/2023. • All residents have the potential to be affected by this alleged deficient practice. On 5/3/23, the night shift supervisor conducted an audit of all resident charts to ensure that there were no other hard scripts in resident charts. No other issues were noted. • All licensed nurses will be in-serviced on the facility policy/procedure for admitting a resident from the hospital with new prescriptions.	06/09/2023

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F 755	Continued From page 12 hard scripts for narcotic medications, and they were accessible in the Resident's chart. On 5/3/23 during clinical record review a review of the hard (paper chart) was conducted and it was found that there were prescriptions for Oxycodone (narcotic pain medication and controlled substance), as well as Lyrica (used for neuropathic pain and also a controlled substance) in the chart. On 5/3/23 at 4:00 PM and interview was conducted with LPN B who was asked the procedure for admitting a Resident from the hospital with new prescriptions. LPN B stated that the prescriptions should be faxed to the pharmacy and placed in the folder in the medication room for the pharmacy to pick up. When asked if the prescriptions should be kept in the hard chart, she stated that they should not. When asked why it would not be kept there, she stated that it would prevent diversion of the script. On 5/3/23 at 5:00 PM an interview was conducted with the DON who stated that LPN B was correct the prescription should not be left in the chart for any reason. The prescription should be placed in the folder for pharmacy to pick up. On 5/4/23 during the end of day meeting the administrator was made aware of the concerns and no further information was provided.	F 755	Continued From page 12 F755 • All new/re-admission charts will be reviewed daily during clinical meetings by the ADON to ensure that charts are free of hard scripts. This will take place Monday-Friday for 4 weeks, and then remain in place moving forward. The results of these audits will be reviewed in the Quality Assurance Committee monthly meetings for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plans of correction as indicated.	06/09/2023
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 757		

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F 757	Continued From page 13 drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free from unnecessary medications for 1 Resident in a survey sample of 25 Residents. The findings included: For Resident #37 the Medical Director ordered several narcotic medications including duplicate orders for PRN Oxycodone. On 5/2/23 at approximately 3:30 PM an interview was conducted with Resident #37 she stated that she used to go to pain management but no longer wants to go there. She stated that the doctor at the facility will manage her pain medications now. Resident #37 had been recently re-admitted to	F 757	F757 • Resident #37 continues to reside in the facility. The Medical Director discontinued the duplicate order for PRN Oxycodone on 5/3/2023. The resident was clinically assessed, no adverse affects noted. • All residents receiving medications have the potential to be affected by this alleged deficient practice. A review of physician's orders was conducted for residents who receive narcotic medications to ensure that their drug regimen is free from unnecessary drugs. No other issues noted. • All licensed nurses will be in-serviced by the DON or designee on the facilities process for verification of resident medications with the physician.	06/09/2023

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F 757	Continued From page 14 the facility after a hospital stay. Resident #37 had diagnosis that included but were not limited to cervical spinal stenosis causing upper body pain, and osteoarthritis. On 5/3/23 a review of the clinical record was conducted, and it was found that Resident #37 was prescribed the following medications for pain when re-admitted back to the facility after a hospital stay. "5/1/23 - Lyrica - (Pregabalin) 75 mg by mouth three times daily for pain." (Lyrica is a seizure medication used for treatment of neuropathic pain) "5/2/23-Methocarbamol 500 mg tablet by mouth 4 times a day as needed for muscle spasm" (Methocarbamol is a muscle relaxer) "5/1/23 - OxyContin 20 mg. tablet, crush resistant extended release, 1 tablet by mouth 3 times per day for pain" (OxyContin is a narcotic pain medication) "5/3/23 - Oxycodone-acetaminophen 5/325 mg. one tablet by mouth twice daily" (Oxycodone is a narcotic pain medication) "5/2/23 - Oxycodone acetaminophen 5/325 mg one tablet by mouth every 4 hours as needed for pain" (Oxycodone is a narcotic pain medication) "5/2/23 - Oxycodone acetaminophen 5/325 mg one tablet by mouth every 6 hours as needed for pain" (Oxycodone is a narcotic pain medication) "5/2/23 - Nucynta 75 mg 1 tablet by mouth every 6 hours PRN pain" (Nucynta is a narcotic pain medication. On 5/4/23 at 3:00 PM an interview was conducted with the Medical Director who was asked about the duplicate medication therapy of narcotic pain medications. The Medical director explained that	F 757	Continued From page 14 F757 • The Medical Director will be in-serviced by the DON or designee on the facilities process for verification of resident medications with the nursing staff. • The facility is transitioning to Point Click Care EMR software on June 1, 2023. The Physician will then be able to input his own orders, avoiding the potential for inaccurate transcription in the future. The DON or designee will audit physician's orders for narcotics weekly times 4 weeks. The results of these audits will be reviewed in the Quality Assurance Committee monthly • meetings for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plans of correction as indicated.	06/09/2023

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F 757	Continued From page 15 prior to coming to the facility the Resident was at another nursing facility and not happy with the care. He stated that she was seeing a Pain Management specialist however did not want to continue seeing them. The medical director stated that he would manage her pain however he did recommend that she see a neurosurgeon for her spinal stenosis and that she see another pain management specialist, and a rheumatologist. When asked about the duplicate Oxycodone orders he stated that he noticed Resident # 37 not making use of the PRN medication and suggested that LPN B offer it to her twice a day. He stated that the nurse must have put in the order for twice a day scheduled. He stated that he would discontinue the routine dose. The Medical Director also stated that he had "discontinued" some of her medications, but they restarted them at the hospital. On 5/4/23 at approximately 3:45 PM an interview was conducted with the LPN B who was asked the procedure for a resident who comes from the hospital to the facility. LPN B stated that when a Resident is admitted to the facility the nurse calls the MD or Nurse Practitioner and verifies the orders with them. When asked how the verification process works, she stated that the nurse reads off the medications and the doctor approves or disapproves. She stated at that time the MD has the choice to keep the orders from the hospital or change them. On 5/4/23 during the end of day meeting the Administrator was made aware of the concerns with the narcotic pain medications and no further information was provided.	F 757		
F 760	Residents are Free of Significant Med Errors	F 760		

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F 760 SS=D	Continued From page 16 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility documentation review, the facility staff failed to ensure that one Resident (Resident #145) was free from a significant medication error, where insulin was administered and was not ordered, in a survey sample of 25 Residents. The findings included: On 5/3/23, at approximately 8:30 AM, Resident #145 was visited in his room. During the interview, Resident #145 expressed concern over his blood sugars and said that he had several occurrences of hypoglycemia and was having difficulty managing his blood sugars. On 5/4/23, a clinical record review was conducted of Resident #145's chart. This review revealed that Resident #145 had orders for sliding scale insulin. The physician order read, "Humalog Kwik Pen Insulin 100 unit/mL subcutaneous, Administer Humalog insulin per blood sugar sliding scale. Sliding scale subcutaneous 4 times a day at 7:30 AM; 11:30 AM; 4:30 PM and 10 PM as follows: Less than 70 follow hypoglycemic protocol and call MD. For BS [blood sugar] 70-150= No Insulin; 151-200= 3 units; 201-250= 6 units...". Review of the Medication Record for Resident #145 for the month of April revealed that on 4/26/23, Resident #145's blood sugar was 137 at	F 760	F760 • Resident #145 continues to reside in the facility. The resident was clinically assessed on 5/4/2023, no adverse affects noted. • All residents who have physician's orders for blood glucose monitoring have the potential to be affected by this alleged deficient practice. 100% audit of blood glucose monitoring was conducted to ensure compliance with physician's orders. No other issues noted. • All licensed nurses will be in-serviced by the DON or designee on the facility policy for Blood Glucose Monitoring and Treatment.	06/09/2023

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F 760	Continued From page 17 7:30 AM. The nursing staff administered 3 units of insulin. According to the physician order, insulin was not to be administered with a blood sugar reading of 137. On 5/4/23 at approximately 10:30 AM, an interview was conducted with LPN B. LPN B stated that it is important to manage a person's blood sugar because "you don't want them to get hypoglycemic, they can go into shock, or a coma and their kidneys can shut down as well". On 5/4/23 at 12:36 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that when a person's blood sugar is too low, they can go into a coma and "could die". The ADON was shown Resident #145's medication record and confirmed that on 4/26/23, with a blood sugar of 137 no insulin should have been administered. On the afternoon of 5/4/23, Surveyor C met with the attending physician of Resident #145, who was also the medical director for the facility. The doctor confirmed that Resident #145 had some challenges in managing his blood sugars at stable levels. When shown the orders for sliding scale the doctor confirmed that with a blood sugar of 137, no insulin was to be administered. The doctor also confirmed that this could cause the blood sugar to drop to dangerous levels that "could be life threatening". A review was conducted of the facility policy titled, "Blood Glucose Monitoring/Treatment". This policy read, "....2.2 The blood glucose will be obtained as ordered by physician or PRN [as needed] when the resident demonstrates symptoms of hypoglycemia or hyperglycemia. ".	F 760	Continued From page 17 F760 • The ADON will audit the Medication Administration Record 3 times a week for 4 weeks for residents with physicians' orders for Blood Glucose Monitoring and Treatment. The results of these audits will be reviewed in the Quality Assurance Committee monthly meetings for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plans of correction as indicated.	06/09/2023

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F 760	Continued From page 18 Review of the policy titled; "Administration of Drugs" was also reviewed. This policy read, ".. 2.1 All medications shall be administered in accordance with the physicians' instructions and consistent with the standards of practice outlined in the current "A Resource Guide for Medication Management for Persons Authorized Under the Drug Control Act", approved by the Virginia Board of Nursing. ". On the afternoon of 5/4/23, the Administrator and Director of Nursing were made aware of the above concerns. No additional information was provided.	F 760		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §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	F 886		

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F 886	Continued From page 19 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 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	F 886	F886 • There have been no new COVID-19 cases in the facility since 5/1/2023. Testing was conducted in accordance with current CDC and CMS guidance. • All residents have the potential to be affected by this alleged deficient practice. • The DON and ADON/IP were in-serviced on conducting COVID-19 testing in accordance with CDC and CMS guidance/requirements during a COVID-19 Outbreak. • The facility policy for Covid-19 testing was reviewed and updated to ensure that testing will be conducted in a manner consistent with current standards of practice.	06/09/2023

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F 886	Continued From page 20 efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with CDC (Centers for Disease Control) and CMS (Centers for Medicare & Medicaid Services) guidance/requirements during a COVID-19 Outbreak within the facility for 2 out of 3 residential nursing units. The findings included: The facility staff failed to conduct COVID-19 testing on 1/11/23 and 1/13/23 on Nursing Units A and B, following the identification of a COVID-19 Outbreak on 1/9/23. All residents located on Nursing Unit C had tested "positive" for COVID-19 on 1/9/23. On 5/3/23, a group interview was conducted with the Director of Nursing (DON) and the Infection Preventionist (IP). The IP stated that 2 residents on Nursing Unit C had tested positive for COVID-19 on 1/8/23 and on 1/9/23, all residents located on Unit C had tested positive for COVID. Unit C was quarantined and COVID testing was also conducted on Units A and B on 1/9/23. The DON and IP stated that the facility's infection control program includes following all recommended CDC guidelines for COVID-19 testing. The facility's COVID-19 Outbreak testing records, including a timeline, along with the facility's COVID-19 testing policy was requested and received.	F 886	Continued From page 20 F886 • The DON or designee will audit testing compliance during an outbreak when an occurrence of infection arises. The results of these audits will be reviewed in the Quality Assurance Committee monthly meetings for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plans of correction as indicated.	06/09/2023

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F 886	Continued From page 21 On 5/3/23, review of the facility's COVID-19 Outbreak testing records and timeline was conducted and confirmed the COVID-19 outbreak within the facility on 1/9/23. All residents in the facility were tested on 1/9/23, however residents were not tested again until 1/16/23--7 days following the initial outbreak. The resident testing occurrences were provided and confirmed by the IP and DON on 5/3/23. On 5/4/23, a review of the facility policy titled, "COVID-19 Testing Plan", date revised 1/9/2023, subtitle, "1.0--Policy Statement", was conducted and read, "...testing will be conducted in a manner consistent with current standards of practice for COVID-19 to facilitate effective interventions for rapidly detecting and preventing the transmission of COVID-19" and "The facility's Testing Plan will be reviewed frequently and will be modified as needed to reflect current updated guidance from CMS [Centers for Medicare & Medicaid Services], CDC [Centers for Disease Control and Prevention], and state health department recommendations". The CDC document entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated September 23, 2022, page 11, subheading, "Nursing Homes", item 6 "Responding to a newly identified SARS-CoV-2 infection in any HCP [Healthcare Personnel] or resident", read, "Perform testing for all residents and HCP. .. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test, this will typically be at day 1	F 886		

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F 886	Continued From page 22 (where day of exposure is day 0), day 3, and day 5". On 5/4/23, the Medical Director, Facility Administrator, DON, and IP were updated on the findings. No further information was provided.	F 886		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a	F 887	F887 • Residents #2, #16, #19, #39 and #96 continue to reside in the facility. Residents #2, #16, #19, #39 and #96 were all offered the COVID-19 booster and documentation is noted in the residents file. • All residents have potential to be affected by this alleged deficient practice. 100% audit completed of current residents. No other issues noted. • The facility policy "COVID-19 Vaccine was reviewed and updated to ensure all residents are provided the opportunity to be up to date with COVID-19 immunizations and our practices are in line with current standards.	06/09/2023

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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 887	Continued From page 23 COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff record review, staff interview and facility documentation review, the facility staff failed to offer and/or provide up to date COVID-19 immunization for 5 residents, Residents #2, #16, #19, #39, and #96, in a survey sample of 7 residents reviewed for COVID-19 vaccination. The findings include: 1. The facility staff failed to offer and/or provide a COVID-19 bivalent booster vaccine for Residents	F 887	Continued From page 23 • All licensed nurses will be in-serviced on providing/offering the most up to date COVID-19 immunization for residents. • The ADON or designee will audit all new admission charts daily during clinical meetings for 4 weeks to ensure that the COVID-19 booster was offered. The results of these audits will be reviewed in the Quality Assurance Committee monthly meetings for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plans of correction as indicated.	06/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495312	A. BUILDING _____ B. WING _____	05/04/2023

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F 887	Continued From page 24 #2, #16, #19, #39, and #96. On 5/3/23, clinical record reviews were performed and revealed the following: A. Resident #2 completed a primary COVID-19 vaccine series on 4/30/21, however there was no evidence that Resident #2 had been offered or received a COVID-19 bivalent booster dose. B. Resident #16 completed a primary COVID-19 vaccine series on 1/21/21, however there was no evidence that Resident #16 had been offered or received a COVID-19 bivalent booster dose. C. Resident #19 completed a primary COVID-19 vaccine series on 2/10/21, however there was no evidence that Resident #19 had been offered or received a COVID-19 bivalent booster dose. D. Resident #39 completed a primary COVID-19 vaccine series on 2/27/21 and a monovalent booster on 5/9/22, however there was no evidence that Resident #39 had been offered or received a COVID-19 bivalent booster dose. E. Resident #96 was admitted to the facility on 4/19/23. There was no evidence that facility staff assessed the COVID-19 immunization status for Resident #96, including primary COVID vaccination and/or booster doses. On 5/3/23, an interview was conducted with the Director of Nursing (DON) and the Infection Preventionist (IP), both of whom confirmed the facility policies and procedures follow CDC (Centers for Disease Control and Prevention) guidance and recommendations for resident COVID-19 immunization.	F 887		

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F 887	Continued From page 25 The DON stated there were no concerns with the facility's ability to provide COVID immunizations to residents. The DON stated that it is expected for all residents to be provided the opportunity to be up to date with COVID-19 immunizations, including the bivalent COVID booster. On 5/3/23, the DON accessed the clinical records for the residents sampled and verified the findings. The facility's COVID vaccination policy for residents was requested and received. On 5/4/23, review of the facility's policy titled, "COVID-19 Vaccine", date reviewed 1/9/2023, subheading "Policy", was conducted and read, "To reduce morbidity and mortality from Coronavirus disease 2019 (COVID-19), [facility name redacted] will offer vaccination to all residents and employees...". The CDC (Centers for Disease Control and Prevention) document titled, "Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States", updated March 16, 2023, page 3, "Recommendations for COVID-19 vaccine use", subtitle, "Booster vaccination", read, "People ages 6 months and older are recommended to receive 1 bivalent mRNA booster dose after completion of any FDA-approved or FDA-authorized primary series or previously received monovalent booster dose(s)". The CDC (Centers for Disease Control and Prevention) document titled, "Stay Up to Date with COVID-19 Vaccines Including Boosters", updated March 2, 2023, page 2, "COVID-19 Boosters", subtitle, "Updated Boosters", read,	F 887		

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F 887	Continued From page 26 "The updated boosters are called 'updated' because they protect against both the original virus that causes COVID-19 and the Omicron variant BA.4 and BA.5...Updated COVID-19 boosters became available on: September 2, 2022, for people aged 12 years and older...You are up to date with your COVID-19 vaccines when you have completed a COVID-19 vaccine primary series and got the most recent booster dose". The CDC (Centers for Disease Control and Prevention) document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated September 23, 2022, page 2, item 1, read, "1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic...Encourage everyone to remain up to date with all recommended COVID-19 vaccine doses...HCP [Healthcare Personnel], patients, and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine". On 5/4/23, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 887		

State of Virginia

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	VA0135	A. BUILDING: _____ B. WING _____	05/04/2023

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JOHNSON CNTR/FALCONS LANDING	20535 EARHART PLACE POTOMAC FALLS, VA 20165

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 05/03/2023 through 05/05/2023. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey. The census in this 60 licensed bed facility was 45 at the time of the survey. The survey sample consisted of 25 resident reviews and 31 staff reviews.	F 000	State tag See F689 See F755 See F760 • The Administrator and The Admissions Coordinator registered on 5/3/2023 to receive notifications from the Virginia State Police Sex Offender Registry. • The Administrator was educated on the policy/regulation for maintaining active registration with Virginia State Police Sex Offender Registry to receive notifications of registered sex offenders living or working within the same or contiguous zip code. • The Admissions Coordinator was educated on the policy/regulation for maintaining active registration with Virginia State Police Sex Offender Registry to receive notifications of registered sex offenders living or working within the same or contiguous zip code.	06/09/2023
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-370 (B). Please cross reference to F689. 12VAC5-371-300 (A). Please cross reference to F755. 12VAC5-371-220 (B). Please cross reference to F760. 12VAC5-371-150(G) Based on staff interview and facility documentation review, the facility staff failed to register the facility with the Virginia Department of State Police to receive notice of the registration or re-registration of any sex offender within the same or a contiguous zip code area in which the nursing facility is located, affecting all 45	F 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Ashlee Bullock TITLE Health Services Director (X6) DATE

Ashlee Bullock 5/19/23.

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F 001	Continued From page 1 Residents residing in the facility. The findings included: On the afternoon of 5/2/23, an interview was conducted with the Facility Administrator. During this interview the Administrator was requested to provide evidence that the facility was registered with the Virginia State Police (VSP) to receive notifications of registered sex offenders within the local area. The Facility Administrator stated, the facility screened residents prior to their admission to see whether or not they are on the sex offender registry but was not sure about receiving information about people in the local area. The administrator and Director of Nursing confirmed neither of them receive such notifications and would have to check into it. Review of the facility policy titled, "Sex Offender Registry" was conducted. Excerpts from this policy read, "... It is the policy of [facility name redacted] to: maintain active registration with the Virginia State Police Sex Offender Registry ("SOR") and monitor for receipt of electronic notification of registered sex offenders living or working within the same or contiguous zip codes...". On 5/2/23, during an end of day meeting, the facility administrator was made aware of the above findings. On 5/3/23 at approximately 10:30 AM, the Facility Administrator provided the survey team with evidence that they had registered that morning (5/3/23) to receive such alerts. No further information was provided.	F 001	State tag See F689 See F755 See F760 • The Administrator will audit notifications weekly times 4 to ensure compliance with active registration. The results of these audits will be reviewed in the Quality Assurance Committee monthly meetings for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plans of correction as indicated.	06/09/2023