STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495011	A. BUILDING _____ B. WING _____	C 06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE WASHINGTON HEALTH & REHABILITATION	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(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 06/12/2023 through 6/14/2023. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		7/18/23
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan,			

	the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.		

Delphis H Nevins, LNHA 7/06/2023

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

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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E 039	Continued From page 1 (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years,	E 039 1.The Administrator created a calendar for the Maintenance Director to conduct the annual full-scale exercise with documentation as a part of the Emergency Preparedness Plan. 2. All residents and staff of the facility can be affected by the deficient practice. The facility will coordinate the annual full-scale exercise with the Fairfax government to arrange a full scale exercise by 3rd quarter. 3.The Maintenance Director was re-educated on conducting the annual full-scale exercise with documentation of the exercise as a part of the Emergency Preparedness Plan. The Emergency preparedness training and testing program policy was reviewed. 4.The HR Coordinator will monitor education on the Emergency Preparedness Plan upon hire and annually. The Emergency Preparedness Plan will be reviewed annually during the QAPI to validate compliance in conducting the annual full-scale exercise. Results of the monthly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5.Date of Compliance: July 18th, 2023	7/18/23

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E 039	Continued From page 2 opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a	E 039		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/27/2023 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

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E 039	Continued From page 3 narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant	E 039	

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E 039	Continued From page 4 emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency	E 039		

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E 039	Continued From page 5 scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039	

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E 039	Continued From page 6 (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.	E 039		

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E 039	Continued From page 7 *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 039	

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E 039	Continued From page 8 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document	E 039		

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E 039	Continued From page 9 review, the facility staff failed to have a complete emergency preparedness plan. The findings include: The facility staff failed to provide evidence of documentation of the annual full-scale exercises and documentation of the facility's exercise analysis, response, and how the facility updated its emergency program based on the exercise analysis. An interview was conducted with OSM (other staff member) #2, the director of maintenance on 6/14/2023 at 9:02 a.m. When asked if the facility had completed a full-scale exercise with documentation of the exercise, OSM #2 stated the facility does fire drills and disaster drills but he has never done a full scale exercise at this building. OSM #2 stated the new company told them that it was mandatory to have an annual full-scale exercise. Review of the facility's emergency preparedness plan, subsection - "Emergency Drills and Exercises," documented in part, "(Name of Facility) will conduct drills and exercise throughout the year testing the emergency preparedness plans and procedures to ensure that there is reasonable staff response to emergency and disaster situations. These exercises may be facility-wide full scale drills which involved staff present at that time and day, table-top exercises which involve select staff that would be used to identify potential issues that would be address and updated to better respond...5. Use of incident command system and activation of the incident command post should be considered when planning and	E 039	

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E 039	Continued From page 10 executing drill and exercises to aid in understanding and acceptance of NHICS. 7. Drills and exercises may at time involve other individuals including consultants, facilitators, emergency responders such as local fire and police as well as emergency management agents." ASM (administrative staff member) #1, the administrator, was made aware of the above findings on 6/14/2023 at 11:10 a.m.	E 039		
F 000	No further information was provided prior to exit. INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/12/23 through 6/14/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey (VA00056740 - substantiated, no deficiencies; VA00054930 - substantiated with deficiencies; VA00054856 - substantiated, no deficiencies).	F 000		
F 578 SS=D	The census in this 96 certified bed facility was 87 at the time of the survey. The survey sample consisted of 25 current resident reviews and 4 closed record reviews. Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		

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F 578	Continued From page 11 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 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 review an advance directive	F 578	

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F 578	Continued From page 12 and/or have copies of the advance directive documents in the clinical record for two of 29 residents in the survey sample, Resident #48 and #60. The findings include: 1. For Resident #48 (R48), the facility staff failed to evidence documentation of a periodic review of the resident's advance directive. R48 was readmitted to the facility on 6/6/2023. The physician orders dated 6/6/2023 failed to evidence documentation of a code status. The "Admit/Readmit Screener" dated 6/6/2023 documented, "Health care directives/code status - full code." On 6/13/2023 at 12:06 p.m., ASM (administrative staff member) #1, the administrator, stated there is no evidence of an advance directive discussion per what the records indicate. The social worker plans to address this at their next care plan meeting as the resident has expressed they wanted to discuss their advance directives. R48 had a care plan meeting scheduled for next week. An interview was conducted on 6/13/2023 at 4:48 p.m. with OSM (other staff member) #1, the social services director. When asked the process for reviewing the advance directives with a resident, OSM #1 stated it is usually reviewed annually for long term residents. If the resident is a short term resident, then it is reviewed on admission. They also review it if there has been a significant change in a resident's condition. OSM #1 was asked where it was documented, OSM #1	F 578	1. The Social Services Director reviewed and discussed advanced directives with resident #48 with documentation in the clinical record. For resident # 60, the Social Services Director is obtaining the power of attorney paperwork from the family member. The clinical record will be updated once these documents are retrieved. 2. All residents in the facility can be affected by this deficient practice. The facility will audit resident clinical records to validate that advanced directive documentation is in the clinical record. The facility will audit new admissions within the last 30 days to validate that advance directive discussion and review occurred. 3. The Director of Social Services and Admissions Coordinator will be educated on the facility policy for advance directive documentation and discussion. 4. The Director of Social Services/Designee will audit 3 residents per week for 8 weeks for compliance in identifying advanced directive discussion and documentation. The results of the weekly audits will be reported monthly to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. Date of Compliance: July 18, 2023	7/1/8/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE WASHINGTON HEALTH & REHABILITATION	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

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F 578	Continued From page 13	F 578		

stated it is different here from where she came from. Here they have assessments. Before, she stated, she wrote a progress note with the information. OSM #1 stated she was going to review advance directives with (R48) at their care plan meeting next week

The facility policy, "Advance Directives" documented in part, "6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family member and/or his or her legal representative, about the existence of nay written advance directives. 7. Information of whether or not the resident has executed an advance directive shall be displayed prominently in the medical record....18. The Interdisciplinary Team will periodically with the resident his or her advance directives to ensure that such directives are still the wishes of the resident."

ASM #1, ASM #2, the director of nursing and ASM #3, the regional director of operations, were made aware of the above on 6/13/2023 at 5:27 p.m.

No further information was provided prior to exit. 2. For Resident #60 (R60), the facility staff failed to maintain the resident's healthcare power of attorney document in the clinical record.

A social services assessment dated 6/6/22 documented R60 had a healthcare power of attorney in place. Further review of R60's clinical record failed to reveal the

	healthcare power of attorney document and failed to reveal documentation that the facility staff attempted to obtain the document.		

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F 578	Continued From page 14 On 6/13/23 at 4:57 p.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 stated that if a resident has a healthcare power of attorney in place, then she would request a copy of the document. OSM #1 stated that if she obtained a copy of the document then she would make sure the document was in the clinical record. OSM #1 stated that if she was unable to obtain a copy of the document then she would document that she requested the document or print out an email to evidence her attempt to obtain the document. On 6/13/23 at 5:31 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 578	
F 655 SS=D	The facility policy titled, "Advance Directives" failed to document information about maintaining power of attorney documents on the clinical record. 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	F 655	

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F 655	Continued From page 15 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) PASRR 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- (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 staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to develop a baseline care plan for the use of an anticoagulant for one of 29 residents in the survey sample, Resident #285. The findings include:	F 655	1. No corrective action can be taken as the baseline care plan for resident #285 was not completed in the allowable time frame. The comprehensive care plan was completed and reviewed with resident #285. 2. All new admissions have the potential to be affected by the deficient practice. An audit will be done for the past 30 days to ensure residents are given a copy of their care plan. The baseline care plan will be completed within 48-hours and given to the resident. 3. Licensed nurses received education on facility policy and procedure for developing a baseline care plan for resident admissions within 48-hours. 4. The Director of Nursing/designee will audit 3 residents weekly for 8 weeks to ensure that the residents' base-line care plan is completed within 48 hours and documented as given to the resident at the discharge planning meeting held within 72 hours of admission. The results of the weekly audits will be submitted to the QAPI Committee monthly x 3. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date Of Compliance- July 18th 2023	7/18/23

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F 655	Continued From page 16 Resident #285 (R285) was admitted to the facility on 6/8/2023. Review of the clinical record failed to evidence a baseline care plan regarding use of an anticoagulant. The MDS (minimum data set) assessment was not due at the time of the survey. The admission nursing assessment dated 6/8/2023 documented the resident being alert and oriented to person, place, time and situation. The assessment failed to evidence documentation of R285 receiving anticoagulant medications. The assessment included baseline care plan triggers which failed to evidence documentation of anticoagulant medications. The physician orders for R285 documented in part, "Apixaban Oral Tablet 5 MG (milligram) (Apixaban) Give 1 tablet by mouth every 12 hours for A Fib (atrial fibrillation). Order Date: 06/08/2023." The progress notes for R285 documented in part, "06/08/2023 19:41 (7:41 p.m.) Admit/Readmit Summary...A baseline care plan has been initiated. A copy of the baseline care plan and any revisions will be provided to [Name of R285] and/or representative on or before the comprehensive care plan meeting..." On 6/13/2023 at 4:27 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that the baseline care plan was completed by the nurse who admitted the resident and completed the admission assessment. RN #1 stated that during the assessment the computer generated the care plan based on the nurse's answers. RN #1 stated that normally the unit	F 655		

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F 655	Continued From page 17 manager reviewed the care plan the day after admission to make sure it was accurate. RN #1 stated that the purpose of the care plan was for the staff to use to care for the patient. RN #1 stated that anticoagulant medication use should be addressed on the baseline care plan because they monitored residents for bleeding by looking for bruising, blood in urine or stool every shift. RN #1 stated that the monitored was done due to the risk of bleeding with anticoagulants. RN #1 stated that the nurse should go through the medications that the resident was ordered on admission and address them on the care plan. The facility policy "Baseline Care Plans" undated, documented in part, "...A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission...The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: a. initial goals based on admission orders; b. Physician orders..." On 6/14/2023 at approximately 10:00 a.m., ASM #1, the administrator was made aware of the findings. No further information was provided prior to exit. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 655		
F 657 SS=D		F 657		

	§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of		

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F 657	Continued From page 18 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to review and revise the comprehensive care plan for one of 29 residents in the survey sample, Resident #60. The findings include: For Resident #60 (R60), the facility staff failed to review and revise the resident's comprehensive care plan for the use of an incentive spirometer (1). On the most recent MDS (minimum data set), a	F 657 1. No physician order was in place for the incentive spirometer found at the bedside. The license nurse consulted with the physician and determined that the use of the incentive spirometer was not medically necessary for resident #44. 2. All residents that use oxygen or respiratory related equipment can be affected by the deficient practice. The facility will conduct an audit on comprehensive care assessments to validate that the comprehensive care plan addresses all the resident needs. 3. Licensed nursing staff of the facility will be provided with education on the facility policy for comprehensive care plans. 4. The Director of Nursing/designee will perform an audit of up to three comprehensive care assessments each week for 8 weeks to validate the care plans are addressing all the resident needs. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. Date Of Compliance- July 18th 2023	7/1/8/23

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F 657	Continued From page 19 quarterly assessment with an ARD (assessment reference date) of 6/2/23, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact. R60's diagnoses included but not limited to, secondary pulmonary hypertension and obstructive sleep apnea. On 6/12/23 at 12:29 p.m., R60 was observed sitting up in bed. An incentive spirometer was observed sitting on the resident's nightstand. R60 stated they use the incentive spirometer every now and then. On 6/13/23 at 8:45 a.m., the incentive spirometer was observed on the resident's nightstand. A review of R60's comprehensive care plan dated 5/25/22 failed to reveal documentation regarding incentive spirometer use. There was no physician order for the use of the incentive spirometer. On 6/13/23 at 2:48 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated, "We care plan everything. It tells you what to do, when to do and what to look for and the diagnosis for that. It guides you as a nurse." LPN #1 stated a resident's incentive spirometer use should be on the care plan. On 6/13/23 at 5:31 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Care Planning - Comprehensive Person-Centered" documented, "16. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care	F 657		

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F 657	Continued From page 20 plans..." Reference: (1) The spirometer is a device used to help you keep your lungs healthy. Using the incentive spirometer teaches you how to take slow deep breaths. https://medlineplus.gov/ency/patientinstruction s/0 00451.htm	F 657		7/18/23
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide treatment to promote healing of a pressure injury for one of 29 residents in the survey sample, Resident #36. The findings include: For Resident #36 (R36), the facility staff failed to	F 686	1. No corrective action can be taken for resident #36, they were discharged from the facility. 2. Residents with pressure ulcers can be affected by this deficient practice. The facility audited resident's clinical records to validate that physician orders for pressure ulcers were performed. 3. Licensed nurses were educated on the facility policy for pressure ulcer prevention and management. 4. The Director of Nursing/designee will audit up to 3 residents with pressure ulcers weekly for 8 weeks to validate pressure ulcer treatment order compliance. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5. Date Of Compliance July 18th, 2023	

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F 686	Continued From page 21 evidence treatment to a pressure injury (1) initially observed on 4/5/2023. A treatment was not started until 4/12/2023. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/30/2023, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. Section M documented R36 having one unstageable pressure injury. On 6/13/2023 at 11:00 a.m., an observation was made of RN (registered nurse) #3, the wound nurse, providing wound care to R36's pressure injury to the left heel. There were no concerns with the pressure injury treatment observation. The progress notes for R36 documented in part; "04/05/2023 08:05 (8:05 a.m.) Skin. Note Text : Resident is alert and verbally responsive. Resident was assessed during weekly body audits. Area identified includes: L-Heel (DTI): Impaired skin integrity measuring 2.0 cm (centimeter) (L) (length) x 2.0 cm (W) (width). x 0.1 cm (depth). Tissue type is 100% Necrotic with no drainage. Periwound is erythematous. PUSH: 11. This skin condition was [sic] remains the same since last evaluated. Tx: Apply Betadine pad and cover with dry dsg. Q (every) Day shift and PRN (as needed)...Preventative measures in place at this time, such as sage boats on while in bed, daily wound treatment, and encourage turning & repositioning by staff while in bed and as tolerated. Resident/RP (responsible parties) and all disciplines made aware of treatment plan. MD (medical doctor) Notified."	F 686	

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F 686	Continued From page 22 The physician orders for R36 documented in part, - "DTI (deep tissue injury) (2) to L-Heel: Apply Betadine pad and cover with dry dsg (dressing) every day shift for wound care and as needed for wound care. Order Date: 4/11/2023 16:47 (4:47 p.m.)." - "Body audit every evening shift Mon (Monday) for skin observation. Order Date: 10/11/2021." The eTAR (electronic treatment administration record) for R36 dated 4/1/2023-4/30/2023 documented in part, "DTI to L-Heel: Apply Betadine pad and cover with dry dsg every day shift for wound care. Start Date: 04/12/2023 0700 (7:00 a.m.)." The eTAR documented the treatment to the left heel pressure injury beginning on 4/12/2023. The eTAR further documented Body Audits completed every evening shift on Mondays for skin observation. The eTAR documented a body audit completed on 4/3/2023. The eTAR for R36 dated 3/1/2023-3/31/2023 documented body audits completed on 3/6/2023, 3/13/2023, 3/20/2023 and 3/27/2023. The wound physician assessment dated 4/12/2023 for R36 documented in part, "...Wound #1 Left Heel is a chronic Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 2 cm length x 2 cm width x 0.1 cm depth, with an area of 4 sq cm (square centimeters) and a volume of 0.4 cubic cm....Plan: Wound Orders: Wound #1 Left Heel. Cleanse/Protect Wound, Cleanse wound with normal saline. Wound dressing: Apply: - Apply Betadine pad and cover with dry dsg Q day	F 686		

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F 686	Continued From page 23 and evening shift and prn..." On 6/13/2023 at 12:52 p.m., an interview was conducted with RN #3, wound nurse. RN #3 stated that the staff conducted weekly wound assessments and any newly identified wounds were assessed, reported to the physician and a treatment order was obtained until the wound physician came in the next Wednesday to assess, measure and make any changes to the treatment as needed. RN #3 stated that R36 had a history of the pressure injury on the left heel and it had healed and reopened in the past and was last healed in September of 2020. RN #3 reviewed R36's clinical record and stated that the left heel pressure injury was first identified as reopening on 4/5/2023 and they had contacted the physician for a treatment order. RN #3 stated that they did not see a physician order for the treatment until 4/12/2023 and there was no evidence that a treatment was done between 4/5/2023 to 4/11/2023. RN #3 stated that if it was not documented they could not evidence that it was done. The facility policy, "Pressure Injury Prevention and Management" documented in part, "...Treatments, including preventative interventions, will be documented in the resident's medical record... On 6/13/2023 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of operations were notified of the findings. No further information was provided prior to exit.	F 686	

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Continued From page 24

Reference:

(1) Pressure injury
A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructi on s/0 00740.htm.

(2) DTI- deep tissue injury
Pressure sores that develop in the tissue deep below the skin. This is called a deep tissue

F 694
SS=E

injury. The area may be dark purple or maroon. There may be a blood-filled blister under the skin. This type of skin injury can quickly become a stage III or IV pressure sore. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructi on s/0 00740.htm

Parenteral/IV Fluids
CFR(s): 483.25(h)

§ 483.25(h) Parenteral Fluids.

F 686

F 694

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE WASHINGTON HEALTH & REHABILITATION	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(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 694	Continued From page 25 Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's 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 monitoring of a resident receiving TPN (total parenteral nutrition) consistent with professional standards of practice for one of 29 residents in the survey sample, Resident #84. The findings include: For Resident #84 (R84), the facility staff failed to monitor blood glucose levels while receiving TPN (1). R84 was admitted on 3/9/22, hospitalized on 3/17/22, then readmitted and d/c'd on the same day 4/1/22. On the most recent MDS (minimum data set) an admission assessment with an ARD (assessment reference date) of 3/13/2022, the resident was assessed as receiving parenteral/IV (intravenous) feeding while at the facility and receiving 51% or more of their total calories through the parenteral feeding. The physician orders for R84 documented in part, - "TPN Therapy per physician order (reminder: check for additional medications to be added by nurse):	F 694	1. No corrective action can be taken for resident #84, they were discharged from the facility. 2. All residents receiving total parenteral nutrition in the facility can be affected by the deficient practice. The facility will audit new admissions physician orders to identify residents who receive total parenteral nutrition. 3. Licensed nurses were educated on the facility policy for total parenteral nutrition care procedure. 4. The Director of Nursing/designee will audit 3 residents for an order for total parenteral nutrition. These residents will be monitored by the facility for compliance for residents receiving total parenteral nutrition. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5. Date Of Compliance- July 18th 2023	7/18/23

	Solution: __ ; Volume: 2000 ; Rate: 50 ; Frequency: Q (every) 12 per IV. Catheter			

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F 694	Continued From page 26 type/size: 10 drops/ml every 12 hours for Small Bowell [sic] Obstruction. Order Date: 03/09/2022." - "CMP (comprehensive metabolic panel), CBC (complete blood count), magnesium, phosphate, triglyceride, total bilirubin every night shift every Monday. Order Date 3/13/2022." A review of R84's progress notes from 3/9/2022-4/1/2022 failed to evidence blood glucose monitoring. A review of R84's eMAR (electronic medication administration record) dated 3/1/2022-3/31/2022 and 4/1/2022-4/30/2022 failed to evidence documentation of blood glucose monitoring. A review of R84's eTAR (electronic treatment administration record) dated 3/1/2022-3/31/2022 and 4/1/2022-4/30/2022 failed to evidence documentation of blood glucose monitoring. The comprehensive care plan for R84 documented in part, "Nutritional/hydration status as evidenced by TPN, GJ (gastrojejunal) Tube, therapeutic diet, underweight BMI, hx/dx/meds (history/diagnosis/medications) Date Initiated: 03/10/2022. Revision on: 03/10/2022." The nutritional assessment for R84 dated 3/13/2022 documented in part, "...Parenteral feeding: Yes. Reason for parenteral feeding: Small bowel obstruction. Order/Rate/Volume: 2000ml (milliliter) Vol (volume): 90ml x1 hr (hour); 182ml x 10 hr, 90 ml x 1 hr. Composition: Dextrose: Grams: 300; Dextrose: Calories: 1020...TPN providing 100% of needs...BMI (body mass index) below reference range. Labs indicate hyponatremia (low sodium) and hyperphosphatemia (high phosphate) as well as	F 694	

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F 694	Continued From page 27 increased BUN (blood urea nitrogen) level. Spoke to pharmacy about adjusting TPN. Recommended to increase fluid volume to 2250ml, decrease protein to 90g (gram) and increase dextrose by 7g for 307g dextrose, and increased by 2g fat for 52 total grams of lipids. Labs didn't indicate a glucose or potassium level. Will follow up with MD (medical doctor)..." On 6/13/2023 at 2:42 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that they did not remember R84 but worked with residents at the facility receiving TPN. RN #1 stated that the facility monitored labs on the residents weekly which they sent to the pharmacy to adjust the dosing of the TPN and they also monitored blood glucose each day depending on the physician's orders. On 6/14/2023 at 8:25 a.m., an interview was conducted with RN #4. RN #4 stated that they worked with R84 when they were at the facility. RN #4 stated that residents who received TPN had weekly labs monitored that determined the dosing and makeup of the TPN by the pharmacy and also the nurses monitored the residents blood sugars routinely each day. RN #4 stated that the blood sugars were monitored at least twice a day unless the resident was diabetic and then they were four times a day. RN #4 reviewed the clinical record and stated that they were unable to find any blood sugar monitoring for R84. On 6/14/2023 at 9:16 a.m., an interview was conducted with ASM (administrative staff member) #4, medical doctor. ASM #4 stated that they did not remember R84 when they were at the facility. When asked if resident's receiving	F 694		

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F 694	Continued From page 28 TPN should have the blood sugar monitored, he stated, "Definitely." He stated that the blood sugar should be monitored based on the resident's history, diagnoses and prior range of blood sugars. ASM #4 stated that the facility staff monitored for clinical symptoms and things like infection, bacteremia, dehydration could alter the blood sugar. He stated that the setting was different from the hospital with staff caring for 18-20 residents and if R84 were stable the staff may have been able to monitor the blood sugar less often. The facility policy "Total Parenteral Nutrition Care Procedure" dated 2015 documented in part, "Clinical considerations: ... 2. Hypoglycemia: Hypoglycemia secondary to total parenteral nutrition are the same as those associated with poorly managed diabetes and they include a headache, a low blood glucose level, shakiness, clammy and cool skin, blurry vision, diaphoresis and unconsciousness and seizures. This complication of total parenteral nutrition, like hyperglycemia, can be prevented with the close monitoring of the resident's blood glucose levels and an adequate dosage of insulin as based on these levels. 3. Hyperglycemia: Hyperglycemia can occur as the result of the high dextrose content of the total parenteral nutrition solution as well as the lack of a sufficient amount of administered insulin. The signs and symptoms of hyperglycemia secondary to total parenteral nutrition are the same as those associated with poorly managed diabetes and they include a high blood glucose level, thirst, excessive urinary output, headache, nausea and fatigue. This total parenteral nutrition complication can be prevented with the continuous monitoring of the resident's blood glucose levels and the titration of	F 694	

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F 694	Continued From page 29 insulin administration as based on these levels....Capillary or serum blood glucose levels: QID (4 times a day) capillary blood glucose initially to monitor glycemic control, then reduce monitoring when blood sugars are stable or as per agency policy. May be done more frequently if glycemic control is difficult. Indicates metabolic tolerance to dextrose in TPN solution and resident ' s glycemic status..." According to Lippincott Manual of Nursing Practice 10th edition page 753 documented in part, "Table 20-3, Complications of Total Parenteral Nutrition and Treatment...Complications: Hyperglycemia; Causes: Insufficient insulin secretion, High glucose content of fluid, blood sample contaminated by parenteral nutrition. Interventions: Monitor blood glucose frequently..." According to Fundamentals of Nursing 8th edition, Potter & Perry, pages 1021-1023 documented in part, "...Parenteral nutrition (PN) is a form of specialized nutrition support in which nutrients are provided intravenously...Safe administration depends on appropriate assessment of nutrition needs, meticulous management of the central venous catheter (CVC), and careful monitoring to prevent or treat metabolic complications...Clinical and laboratory monitoring by a multidisciplinary team is required throughout PN therapy..." It further documented, "Table 44-8 Metabolic Complications of Parenteral Nutrition...Problem: Hyperglycemia; Signs/Symptoms: Thirst, headache, lethargy, increased urination. Intervention: Monitor blood glucose level every 6 hours..."	F 694		

	On 6/14/2023 at 10:00 a.m., ASM #1, the		

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F 694	Continued From page 30 administrator was informed of the concern. No further information was provided prior to exit. Reference: (1) Total parenteral nutrition (TPN) is a method of feeding that bypasses the gastrointestinal tract. A special formula given through a vein provides most of the nutrients the body needs. The method is used when someone can't or shouldn't receive feedings or fluids by mouth. A person may need TPN for a short time over weeks or months, or for life. It depends on the condition that causes the need for TPN. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructi on s/0 00177.htm	F 694	
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 observations, resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide respiratory care and services for two of 29 residents in the survey sample, Resident #285 and Resident #60.	F 695	

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F 695	Continued From page 31 The findings include: 1. For Resident #285, the facility staff failed to obtain a physician's order for the use of oxygen. The MDS (minimum data set) assessment was not due at the time of the survey. The admission nursing assessment dated 6/8/2023 documented the resident being alert and oriented to person, place, time and situation. The assessment documented Resident #285 (R285) receiving oxygen at the facility. On 6/12/2023 at 1:57 p.m., an interview was conducted with R285 in their room. R285 was observed in bed wearing an oxygen nasal cannula. R285 stated that they wore oxygen at all times during the day and wore a CPAP (continuous positive airway pressure) at night due to congestive heart failure. R285 was observed to be receiving oxygen at 2.5 liters per minute. Additional observations of R285 receiving oxygen at 2.5 liters per minute were made on 6/12/2023 at 4:30 p.m. and 6/13/2023 at 8:55 a.m. A review of the physician orders for R285 failed to evidence an order for oxygen. The progress notes for R285 documented in part, "06/08/2023 23:21 (10:21 p.m.) Admit/Readmit ...93% (oxygen saturation) NC (nasal cannula) at 2 liters..." The progress notes further documented, "06/08/2023 19:41 (7:41 p.m.) Admit/Readmit Summary...(Name of R285) will receive the following specialized services during this stay: Oxygen..." The baseline care plan for R285 documented in	F 695	1. The physician's order for resident #285 for the use of oxygen was obtained. The incentive spirometer for resident #60 was discontinued. 2. Residents receiving respiratory services can be affected by this deficient practice. An audit of the facility will be conducted that include room-to-room observations to ensure that physician orders are present for any identified respiratory equipment. 3. Licensed nurses were educated on the facility policy for physician orders, storage, and monitoring of respiratory equipment and that resident care plans will accurately reflect care being provided to the resident. 4. The Director of Nursing/designee will audit 3 random resident rooms observing for the presence of respiratory services and equipment weekly for 8 weeks for compliance with physician orders for oxygen administration and respiratory equipment. Results of the weekly audits will be submitted to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date Of Compliance- July 18th 2023	7/18/23

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F 695	Continued From page 32	F 695		

part, "The resident has oxygen therapy. Date Initiated: 06/08/2023."

On 6/13/2023 at 1:30 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that when they received new admissions to the facility they reviewed the discharge summary from the hospital with the physician to approve the orders and then entered the orders into the computer. She stated that R285 came from the hospital receiving oxygen and wore it all the time and that there should be an order for the oxygen so the staff knew the amount of oxygen prescribed. LPN #3 reviewed R285's physician orders and stated that they did not see an order for the oxygen and that it may not have been transcribed.

On 6/13/2023 at 2:42 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that residents who were admitted to the facility from the hospital with oxygen came with an order for the oxygen which the nurse reviewed, verified with the facility physician and transcribed into the electronic medical record physician orders.

The facility policy "Oxygen Administration" undated, documented in part, "...Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration..."

On 6/13/2023 at approximately 5:30 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of operations were made aware of the findings.

No further information was provided prior to exit.

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F 695	Continued From page 33 2. For Resident #60 (R60), the facility staff failed to obtain a physician's order for the use of an incentive spirometer (1) and failed to store the incentive spirometer in a sanitary manner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/2/23, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact. A review of R60's clinical record failed to reveal a physician's order for an incentive spirometer. R60's comprehensive care plan dated 5/25/22 failed to document information regarding the use of an incentive spirometer. On 6/12/23 at 12:29 p.m., R60 was observed sitting up in bed. An incentive spirometer was observed on the resident's nightstand. The incentive spirometer mouthpiece was uncovered and exposed to air. R60 stated they use the incentive spirometer every now and then. On 6/13/23 at 8:45 a.m., R60 was observed sitting up in bed. The incentive spirometer remained uncovered on the resident's nightstand. On 6/13/23 at 5:17 p.m., an interview was conducted with R60. R60 stated staff has never covered the incentive spirometer. On 6/13/23 at 2:48 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated residents should have a physician's order for an incentive spirometer, so nurses know how to use the device and how often to use the device. LPN #1 stated an	F 695	

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F 695	Continued From page 34 incentive spirometer should be stored in a bag for infection control. On 6/13/23 at 5:31 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Incentive Spirometry" documented, "To have patient perform sustained maximal inspiration without added resistance or positive pressure while presenting visual feedback of effort. Incentive Spirometry can be instructed/administered by an Respiratory Care Practitioner upon written physician's order." Reference: (1) The spirometer is a device used to help you keep your lungs healthy. Using the incentive spirometer teaches you how to take slow deep breaths. https://medlineplus.gov/ency/patientinstruction s/0 00451.htm	F 695		
F 697 SS=E	Pain Management 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 staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a pain management program per physician orders, for	F 697		

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F 697	Continued From page 35 one of 29 residents in the survey sample; Resident #72. The findings include: For Resident #72, the facility staff failed to implement parameters for an as-needed (PRN) pain medication that was ordered for "severe" pain. The facility staff administered the medication for pain levels that were less than severe (mild or moderate) on a pain scale of 0-10 with 10 being the most severe level of pain. A review of the clinical record revealed a physician's order dated 4/28/23, discontinued on 5/5/23 and reordered on 5/6/23 for oxycodone-acetaminophen (1) 10-325 mg, give one tab every four hours as needed for severe pain. There were no orders for any PRN pain medication for levels that would be considered mild or moderate. A review of the Medication Administration Record (MAR) for May 2023 and June 2023 revealed the resident received this medication on the following dates for the following pain ratings that fell below the level of "severe." On 5/2/23 the medication was administered for a pain level of a 5. On 5/4/23 the medication was administered twice for pain levels of a 5. On 5/9/23 the medication was administered twice for pain levels of a 5. On 5/10/23 the medication was administered for a pain level of a 5.	F 697	1. Resident #72 was provided with pain management parameters per physician orders and care plan was updated. 2. Residents receiving pain management services can be affected by this deficient practice. The facility conducted an audit on all residents receiving pain management services to validate that physician orders with parameters were in place and care plans updated. 3. Licensed nurses were educated on the facility policy for pain management to include parameters and monitoring of effectiveness of pain medications and non-pharmacological interventions. 4. The Director of Nursing/designee will audit a sample of 3 residents weekly for 8 weeks to ensure compliance with pain management parameters per physician orders with care plans updated. The results of the weekly audits will be submitted to the QAPI Committee monthly x 3. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date of Compliance-July 18, 2023	7/18//23

	On 5/13/23 the medication was administered for		

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F 697	Continued From page 36	F 697	
	a pain level of a 4. On 5/18/23 the medication was administered for a pain level of a 5. On 5/22/23 the medication was administered for a pain level of a 5. On 5/23/23 the medication was administered for a pain level of a 5. On 5/25/23 the medication was administered for a pain level of a 6. On 5/26/23 the medication was administered for a pain level of a 5. On 5/30/23 the medication was administered for a pain level of a 4. On 5/31/23 the medication was administered twice for pain levels of a 3 and a 4. On 6/4/23 the medication was administered twice for pain levels of a 5 and a 2. On 6/9/23 the medication was administered twice for pain levels of a 5. On 6/12/23 the medication was administered for a pain level of a 5. On 6/13/23 the medication was administered for a pain level of a 3. The facility policy, "Pain Management" was reviewed. This policy documented, "The organization will 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...." The policy did not identify the utilization of the pain scale of 0-10 with 10 being the most severe level of pain, or parameters as to what numbers on the scale constitute mild, moderate and severe levels of pain. On 6/13/23 at 3:19 PM an interview was conducted with LPN #2 (Licensed Practical		

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F 697	Continued From page 37 Nurse). When asked what is considered severe pain she stated it is a 5 and higher. When asked what should staff do when a resident complains of pain that is less than severe, she stated to give the resident a Tylenol (2). When asked what if there isn't an order for Tylenol, she stated that staff would need to call the doctor to get an order. When asked if a resident should be administered Oxycodone that was ordered for severe pain, if their pain level was mild or moderate, she stated that it should not be administered for pain levels that low. When it was noted that on some occasions, she was the nurse that administered the Oxycodone for low pain levels, and when asked if she called the doctor to get an order for Tylenol instead, she stated that she did not. On 6/13/23 at 5:41 PM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing (DON). When asked what is considered a mild pain level, a moderate pain level and a severe pain level on the 0-10 pain scale, she stated that mild would be 0 to 3, moderate would be 4 to 7, and severe would be 8 to 10. When asked if at anytime would a 3 or a 5 be considered a severe pain level, she stated that it was not. When asked if a resident was ordered Oxycodone for severe pain level, should the staff be administering it for pain levels of 3 or 5, she stated that they should not be. No further information was provided by the end of the survey. References: 1. Oxycodone-acetaminophen is used to relieve moderate to severe pain.	F 697		

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GEORGE WASHINGTON HEALTH & REHABILITATION	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

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F 697	Continued From page 38 Information obtained from https://medlineplus.gov/druginfo/meds/a68213 2.h tml 2. Tylenol is used to relieve mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a68100 4.h tml	F 697		
F 756 SS=E	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	F 756		

	address it. If there is to		

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F 756	Continued From page 39 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, the facility staff failed to respond to pharmacy recommendations for two of 29 residents in the survey sample, Residents #60 and #44 The findings include: 1. For Resident #60 (R60), the facility staff failed to respond to pharmacy recommendations dated 8/23/22 and 10/24/22 for lab tests. A review of R60's clinical record revealed a pharmacy recommendation dated 8/23/22 that documented to consider monitoring a liver function test, lipid panel and a basic metabolic panel on the next lab day, and a pharmacy recommendation dated 10/24/22 that documented to consider monitoring a digoxin level on the next lab day. Further review of R60's clinical record failed to reveal these pharmacy recommendations were addressed and failed to reveal the lab results. On 6/14/23 at 10:34 a.m., an interview was conducted with RN (registered nurse) #3. RN #3	F 756	7/18/23

1. For resident #60 The facility contacted the attending physician who declined the pharmacy recommendations. No corrective action can be taken for resident #44, they were discharged from the facility.

2. All residents of the facility can be affected by this deficient practice. Facility will conduct an audit on the most recent pharmacy drug regimen review to identify any pharmacy recommendations for follow up.

3. Licensed nurses were educated on responding to pharmacy recommendations to ensure that resident's entire drug/medication regimen is managed and monitored in a timely manner.

4. The Director of Nursing/Designee will conduct an audit past 30 days of drug regimen reviews to ensure compliance with following pharmacy recommendations. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date Of Compliance- July 18th, 2023

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F 756	Continued From page 40 stated that once the pharmacist has completed their review, the staff print out the pharmacy recommendations, give them to the doctor, and the doctor acts upon them. On 6/14/23 at 10:57 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, "Medication Regimen Review" documented, "9.a) The consulting pharmacist will provide copy of recommendations to the attending physician, medical director, and director of nursing within 5 working days of completion of the review. b) The director of nursing or designee will review the recommendations and the attending physicians will be contacted for review and response..." 2. For Resident #44 (R44), the facility staff failed to evidence documentation of a response to pharmacy recommendations for three months. The pharmacy recommendation for 4/20/2022 documented, "Recommendations: Miconazole Nitrate Cream 2%, Apply to L (left) arm rash topically one time a day. This order does not have a stop date. Please reevaluate therapy and add a stop date. If continued therapy is warranted, please document the rationale for continued use. Additional Recommendations/Suggestions: Evaluate a stop date." The pharmacy recommendation for 6/13/2022, documented, "Recommendations: Miconazole Nitrate Cream 2%, Apply to L (left) arm rash topically one time a day. This order does not have a stop date. Please reevaluate therapy and add a stop date. If continued therapy is warranted, please document the rationale for continued use.	F 756		

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F 756	Continued From page 41	F 756		

Additional Recommendations/Suggestions: Evaluate a stop date."

There was no action taken from the 4/20/2022 recommendation and the pharmacist had to repeat the recommendation on 6/13/2022.

The pharmacy recommendation for 7/13/2022, documented, "Recommendations: Seroquel mg (milligrams) (Quetiapine Fumarate) (1), Give 1 tablet by mouth at bedtime and Trazadone HCL (2) 50 mg Tablet, Give 1 tablet orally at bedtime. Recommended: Please consider a dose reduction. Additional Recommendations/suggestions: Consider discontinuing Seroquel 50 mg and consider Seroquel 25 mg PO (by mouth) HS (bedtime)."

The pharmacy recommendation for 10/25/2022, documented, "Recommendations: Seroquel mg (milligrams) (Quetiapine Fumarate), Give 1 tablet by mouth at bedtime and Trazadone HCL 50 mg Tablet, Give 1 tablet orally at bedtime. Recommended: Please consider a dose reduction. Additional Recommendations/suggestions: Consider discontinuing Seroquel and Trazadone, and consider Seroquel 25 mg HS and Trazadone 100 mg HS."

Review of the clinical record failed to evidence action taken upon these pharmacy recommendations or a provider note to

	document the reason for not changing the doses of medications.		

	The last psychiatry note was dated 4/15/2022. The note documented in part, "Treatment Plan: 1. Dementia -Aricept and Namenda. 2. BPBD -		

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F 756	Continued From page 42 Seroquel on reduced dose, stable." An interview was conducted with RN (registered nurse) #3 on 6/14/2023 at 10:34 a.m. When asked the process for when the pharmacist makes recommendations, RN #3 stated that when they [the pharmacist] does their review, we go into the system [computer] and print out the recommendations. We hand them to the unit managers who takes them to the doctors. Once the doctor has reviewed, the nurse takes the orders and puts them in the computer. The unit manager makes sure this it done. The above concerns were shown to RN #3 for follow up. RN #3 returned at 10:45 a.m. and stated he had nothing related to the above pharmacy recommendations. RN #3 stated he could not find any doctor's notes related to the pharmacy recommendations. The facility policy titled, "Medication Regimen Review" documented, "9.a) The consulting pharmacist will provide copy of recommendations to the attending physician, medical director, and director of nursing within 5 working days of completion of the review. b) The director of nursing or designee will review the recommendations and the attending physicians will be contacted for review and response..." ASM (administrative staff member) #1, the administrator, was made aware of the above finding on 6/14/2023 at 11:10 a.m. No further information was obtained prior to exit. References: (1) Seroquel - Quetiapine extended-release tablets are also used along with other	F 756	

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F 756	Continued From page 43 medications to treat depression. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698 01 9.h tml (2) Trazodone is used to treat depression. This information was obtained from the following	F 756		
F 757 SS=E	website:https://medlineplus.gov/druginfo/me ds /a6 81038.html 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 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 staff interview, facility document review and clinical record review, the facility staff failed to ensure a resident was free from an	F 757		

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F 757	Continued From page 44 unnecessary medication for two of 29 residents in the survey sample, Residents #60 and #285. The findings include: 1. For Resident #60 (R60), the facility staff failed to monitor the resident for side effects (bleeding) from the anticoagulant (1) medication Eliquis (2). A review of R60's clinical record revealed a physician's order dated 4/4/23 for Apixaban (Eliquis) 5 mg (milligrams) by mouth every 12 hours for atrial fibrillation. A review of R60's MARs (medication administration records) for April 2023 through June 2023 revealed the resident was administered Apixaban 5 mg every 12 hours every day. Further review of R60's clinical record (including the MARs, assessments and nurses' notes for April 2023 through June 2023) failed to reveal the resident was monitored for side effects (bleeding) from Apixaban (except for 4/5/23 and 6/9/23). On 6/13/23 at 4:27 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that residents who are administered anticoagulant medication should be monitored for bleeding, bruising, bloody urine or bloody stool every shift. RN #1 stated nurses should document this monitoring, even if no bleeding is observed. RN #1 stated it is important to monitor residents who receive anticoagulant medication because they could bleed to death.	F 757	1. The care plan for resident#60 and resident #285 was revised to monitor the side effects of bleeding and adverse effect monitoring from the anticoagulant medications. 2. Residents receiving an order for anticoagulant medications in the facility can be affected by the deficient practice. The facility will conduct an audit of residents on anticoagulant medications to validate that their care plan is revised to reflect the monitoring of side effects of bleeding and adverse effects monitoring. 3. Licensed nurses were educated on the facility policy for anticoagulant orders, revision of care plans and documentation. 4. The Director of Nursing/designee will conduct an audit of up to 3 resident anticoagulant care plans per week for 8 weeks to validate compliance with monitoring and documentation. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance. 5.Date Of Compliance- July 18th, 2023	7/18/23

	On 6/13/23 at 5:31 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.		

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F 757	Continued From page 45 The facility policy titled, "Medication and Treatment Orders" documented, "Order for anti-coagulants will be prescribed only with appropriate clinical and laboratory monitoring." Reference: (1) Anticoagulants are a family of medications that stop your blood from clotting too easily. https://my.clevelandclinic.org/health/treatment s/2 2288-anticoagulants (2) "ELIQUIS is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation (NVAF)...Bleeding Risk: ELIQUIS increases the risk of bleeding and can cause serious, potentially fatal, bleeding." This information was obtained from the website: https://www.eliquis.com/eliquis/hcp/wellcare for m? cid=sem_2167331&ovl=isi&gclid=64c052d127 00 1aa9ec1836cd1510884c&gclsrc=3p.ds& 2. For Resident #285 (R285), the facility staff failed to monitor for adverse effects of a prescribed anticoagulant (1)medication. The MDS (minimum data set) assessment was not due at the time of the survey. The admission nursing assessment dated 6/8/2023 documented the resident being alert and oriented to person, place, time and situation. The assessment failed to evidence documentation of R285 receiving anticoagulant medications. The physician orders for R285 documented in part, "Apixaban Oral Tablet 5 MG (milligram) (Apixaban) Give 1 tablet by mouth every 12 hours for A Fib (atrial fibrillation). Order Date: 06/08/2023." The eMAR (electronic medication administration record) dated 6/1/2023-6/30/2023 for R285	F 757	

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F 757	Continued From page 46 documented the Apixaban administered beginning on 6/8/2023 at 9:00 p.m. and each day at 9:00 a.m. and 9:00 p.m. through the present. The eMAR failed to evidence anticoagulant adverse effect monitoring. The progress notes for R285 failed to evidence documentation of anticoagulant adverse effect monitoring. Review of the clinical record failed to evidence a baseline care plan regarding use of an anticoagulant. On 6/13/2023 at 4:27 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that they monitored residents for bleeding by looking for bruising, blood in urine or stool every shift due to the risk of bleeding with anticoagulants. RN #1 stated that this was documented in the progress notes every shift whether there was bleeding observed or not. On 6/13/2023 at approximately 5:30 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of operations were made aware of the findings. No further information was provided prior to exit.	F 757		
F 840 SS=D	Reference: (1) Anticoagulants are a family of medications that stop your blood from clotting too easily. https://my.clevelandclinic.org/health/treatment s/2 2288-anticoagulants Use of Outside Resources CFR(s): 483.70(g)(1)(2)	F 840		

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F 840	Continued From page 47 §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g) (2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to evidence a current dialysis contract between the facility and the outpatient dialysis center providing services for one of 29 residents in the survey sample, Resident #27. The findings include: A review of R27's clinical record revealed a physician's order dated 6/12/23 for hemodialysis at (name of company) every Monday, Wednesday and Friday. A review of the facility dialysis contracts failed to reveal a contract for R27's dialysis provider. On 6/13/23 at 4:17 p.m., an interview was	F 840 1. The facility provided a dialysis contract dated June 13, 2023. 2. This deficient practice can affect residents that receive dialysis treatment off campus. 3. The facility administrator continues to work with the dialysis vendor to obtain the original January 21, 2022, dialysis contract. 4. The facility administrator will conduct monthly follow ups with the dialysis vendor on securing the initial contract dated January 21, 2022. Results of these monthly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date Of Compliance- July 18th, 2023	7/18/23

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F 840	Continued From page 48 conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 presented a commercial contract request intake form dated 1/21/22 and stated that she could not provide the dialysis contract. On 6/13/23 at 5:31 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not have a policy regarding dialysis contracts.	F 840		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is	F 842		

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	495011	A. BUILDING _____ B. WING _____	C 06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE WASHINGTON HEALTH & REHABILITATION	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 49 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes;	F 842	1. The comprehensive care plan for resident #48 was revised to reflect an accurate clinical record. 2. All resident admissions can be affected by this deficient practice. The facility will review comprehensive care plans to validate accuracy. 3. The licensed nurse was provided with individual education on accurately completing the comprehensive care plan. Additionally, licensed nurses received education on facility policy and procedure for developing accurate care plans. 4. The Director of Nursing/designee will audit 3 residents weekly for 8 weeks to ensure that the residents' comprehensive care plans are completed accurately. The results of the weekly audits will be submitted to the QAPI Committee monthly x 3. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date of Compliance- July 18th, 2023	7/18/23

	and (vi) Laboratory, radiology and other diagnostic		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495011	A. BUILDING _____ B. WING _____	C **06/14/2023**

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GEORGE WASHINGTON HEALTH & REHABILITATION	**1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308**

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F 842	Continued From page 50 services reports as required under §483.50. 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 maintain an accurate clinical record for one of 29 residents in the survey sample, Resident #48. The findings include: For Resident #48 (R48) the facility staff inaccurately documented in the care plan that the resident was on hospice, had a urinary catheter, and was ventilator dependent. The comprehensive care plan dated 6/6/2023, documented in part, "Focus: The resident has (SPECIFY Condom/Intermittent/Indwelling, Suprapubic) Catheter... Resident was admitted to hospice RT (related to) (diagnosis) with (Hospice Company)...The resident has a tracheostomy...The resident is ventilator dependent r/t." Observation was made of R48 on 6/12/2023 at approximately 12:15 p.m. The resident did not have a tracheostomy. A second observation and interview with R48 was conducted on 6/12/2023 at 4:47 p.m. The resident did not have a tracheostomy and there was no ventilator in the resident's room. When asked if they were on hospice care, R48 stated, no. When asked if they had a catheter of any kind, R48 stated they used the urinal. An interview was conducted with LPN (licensed practical nurse) #3 on 6/13/2023 at 1:58 p.m., a	F 842	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495011	A. BUILDING _____ B. WING _____	C

NAME OF PROVIDER OR SUPPLIER

GEORGE WASHINGTON HEALTH & REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE

1510 COLLINGWOOD ROAD

ALEXANDRIA, VA 22308

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F 842	Continued From page 51 nurse that cares for R48. When asked if R48 had a tracheostomy or catheter, LPN #3 stated, no. LPN #3 was asked if R48 was on hospice care, LPN #3 stated, no. The above care plans were reviewed with LPN #3. LPN #3 stated the care plans were incorrect for that resident. The policy provided, "Electronic Medical Record," did not document anything related to an accurate medical record. ASM #1, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were made aware of the above concern on 6/13/2023 at 5:27 p.m. No further information was provided prior to exit.	F 842		