	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495011	B. WING			441	C
NAME OF		100011				11/	01/2023
	PROVIDER OR SUPPLIER E WASHINGTON HEALTH	1 & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-S	F 0	00			
F 607 SS=D	An unannounced M abbreviated survey through 11/1/23. Co compliance with 42 Long Term Care requirements. One of investigated during - substantiated with The census in this 9 94 at the time of the sample consisted or reviews. Develop/Implement CFR(s): 483.12(b)(1 §483.12(b) The facil implement written possible with the possible facility of the sample consisted or reviews. Develop/Implement CFR(s): 483.12(b)(1) Frobil implement written possible facility of the sample consisted or reviews.	dedicare/Medicaid was conducted 10/31/23 brrections are required for CFR Part 483 Federal complaint was the survey (VA00059865 deficiencies). 66 certified bed facility was e survey. The survey of five current resident Abuse/Neglect Policies 1)-(5)(ii)(iii) lity must develop and olicies and procedures that: bit and prevent abuse, ation of residents and resident property, slish policies and stigate any such	F 6				
	at paragraph §483. §483.12(b)(4) Estab	lish coordination with					
	the QAPI program r §483.75.	required under					
	occurring in federally facilities in accordanthe Act. The policies	re reporting of crimes y-funded long-term care nce with section 1150B of s and procedures must limited to the following					
	§483.12(b)(5)(ii) Pos	sting a conspicuous notice of					

Delphis H Nevins, LNHA 11/17/2023

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES

OLITICIO I OR MEDIO, IRE & MEDIO, ID CERTIFICE CIMB 140					7. 0000 0001		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495011	B. WIN	G		11/0	C 01/2023
NAME OF PROVIDER OR SUPPLIER GEORGE WASHINGTON HEALTH & REHABILITATION					STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE

F 607	Continued From page 1 employee rights, as defined at section 1150B(d) (3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement their policy to report an injury of unknown origin to the State	F 607	Past noncompliance: no plan of correction required.	
	Agency in a timely manner for one of five residents in the survey sample, Resident #1.			
	The findings include:			
	For Resident #1 (R1) the facility failed to implement their policy to report a right chest bruise of unknown origin, discovered 9/25/23; it was not reported to the State Agency until 10/2/23.			
	On the quarterly MDS (minimum data set) with an ARD (assessment reference date) of 9/7/23, R1 was coded as being severely impaired for making daily decisions. She was coded as sometimes able to understand others, and as sometimes understanding others. She was admitted to the facility with a diagnosis of dementia.			
	A review of R1's care plan dated 4/5/22 and updated 10/12/23 revealed, in part: [R1] has difficulty communicating related to decline in cognitive status, lack/limited use/understanding of			
	English (fluent in Spanish)."			
	A review of R1's clinical record revealed the following progress notes:			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT COMPLE	E SURVEY ETED	
		495011	B. WIN	G		11/0	01/2023
NAME OF PROVIDER OR SUPPLIER GEORGE WASHINGTON HEALTH & REHABILITATION					STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE

F 607	Continued From page 2	F 607	
1 007	"9/24/2023 09:30 (a.m.) Nursing Note Text:	1 007	
	Resident noted this morning at 9:00 am		
	shouting loud and speaking in Spanish		
	language. Nurse went in to see what the		
	problem is. Nurse noted resident in Geri-chair		
	showing signs of discomfort and not allowing		
	nurse to touch her left arm. Nurse immediately		
	went in to call nursing		
	supervisor and Spanish staff to help with		
	interpretation of what resident was saying. She		
	told staff that her left arm hurt and also want to		
	go home to her familyAM (morning)		
	prescribed meds given to resident and PRN		
	(as needed) pain med given as well to help		
	with painSitting at nurses' station at the		
	moment with nurse for supervision. All safety		
	measures maintained." This note was written		
	by LPN (licensed practical nurse) #1, who was unavailable for interview during the survey.		
	unavailable for interview during the survey.		
	"9/25/2023 13:44 (1:44 p.m.) Physician/NP		
	(nurse practitioner) Progress Note		
	Text: Chief Complaint: follow up; c/o (complaint		
	of) rt (right) chest wall bruisingPatient is long		
	term resident in here and follow up for c/o rt		
	chest wall bruising noticed by aide. pt (patient)		
	lying on bed, not in distressAssessment /		
	Plan		
	Contusion of right chest wall - rt chest wall		
	under rt axillaclose observation, follow up		
	prn."		
	10/05/0000 44 04 /0 04		
	"9/25/2023 14:01 (2:01 p.m.) Skin		
	Observation Weekly (Licensed Nurse)		
	Note Text: Weekly skin observation		
	completed. Bruise to right arm. Unknown Origin."		
	Origin.		
	"9/25/2023 15:11 (3:11 p.m.) Nursing Note Text:		
	Patient was seen by the visiting MD (physician)		
	this afternoon, head to toe assessment done by		
	the MD on unknown origin of bruises noted @		
	(at)		
	the right arm of the patient, no new order		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495011	B. WING		C 11/01/2023
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
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
	exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown origin re thoroughly investigated by facility managementAll violations involvinginjuries of unknown sourcewill be reported by the facility administrator, or his/her designeeto the state licensing/certification agencyAn alleged violation ofinjuries of unknown sourcewill be reported immediately, but not later thattwo hours if the alleged violation involves abuse or has resulted in serious bodily injuryor 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury." On 11/2/23 at 9:05 a.m., ASM #3, the attending physician, was interviewed. He stated on 9/25/23, a nurse told him about R1's bruising on her right side. He stated the bruising was in somewhat of a line under the armpit along the chest wall. He stated when he touched the area, the resident did not exhibit any expression of tenderness or pain.			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	495011	B. WING	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CEORCE	WASHINGTON HEALTH & DEHADILITATION		1510 COLLINGWOOD ROAD		
GEORGI	E WASHINGTON HEALTH & REHABILITATION		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 607	Continued From page 4 He stated at the time, in the course of his physical assessment, he did not suspect the resident had a shoulder injury. He stated she did not display any physical signs of such an injury on 9/25/23. On 11/1/23 at 10:39 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional nurse consultant, and RN (registered nurse) #1, the assistant director of nursing, were interviewed. ASM #4 stated he came to the facility to help with the investigation of the resident's bruising. ASM #2 stated she and ASM #1 were out of the facility on vacation the week of September 24 and 25, 2023, when the first report of the bruise appeared in the record. ASM #4 stated it took some time to identify which staff members may have been allegedly involved in the injury to R1, and when those staff members were identified, they were suspended pending the results of the investigation. ASM #4 stated the management staff identified that the report to the state agency was not timely, and they put a plan of correction in place. A review of the facility's plan of correction for the lack of timely reporting to the state agency revealed in part, "Abuse and NeglectThe facility reported the injury of unknown origin on 10.2.23 when the NHA (nursing home administrator) and DON (director of nursing) was (sic) made aware of the injury. The facility failed to report timely when the injury was first noted by the nurse on 9/24/23All residents of the facility are at risk to be affected by this	F 607	DEFICIENCY)		
	deficient practice. Abuse screening questionnaire will be completed on residents that are interviewable and have a BIMS (brief interview for mental status) score of 8 (eight) or higher. For non-interviewable residents,				

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	495011	B. WING	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GEORGE WASHINGTON HEAL	TH & REHABILITATION		1510 COLLINGWOOD ROAD	
			ALEXANDRIA, VA 22308	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL 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
abuseAny identified areas wil the facility abuse a the facility will be r abuse and negled focus on types of investigations, and unknown origin. Th provide abuse and facility leadership of add this education orientation. No sta return to work until has been complet an adhoc QAPI (of performance impr 10/9/23 to review a of complianceTh complete abuse qu sample of three re the weekly audits withe QAPI committee committee is response.	will be completed, signs or symptoms of If be addressed according to and neglect policyAll staff of eeducated on the facility at policy. This education will abuse, abuse reporting, direporting of injuries of the Regional Nurse will a neglect training to the pon 10/9/23. The facility will to new hire after members will be allowed to the mandatory education to edThe facility will conduct	F 607		
this plan of correct implemented. This included staff educe modules, interview audits, and opporte the state agency scompliance date of were identified with plan of correction. regarding implement were identified duri	credible evidence cation vs with staff, review of facility unities for facility reports to since the allegation of of 10/9/23. No concerns on the implementation of the No further concerns entation of the abuse policy ing the survey.	F 609		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495011	B. WING	C 11/01/2023

NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
05000	- WASHINGTON HEALTH & BEHABILITATION		1510 COLLINGWOOD ROAD	
GEORGE	E WASHINGTON HEALTH & REHABILITATION		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 609	Continued From page 6 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to report an injury of unknown origin to the State Agency in a timely manner for one of five residents in the survey sample, Resident #1.	F 609	Past noncompliance: no plan of correction required.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	495011	B. WING	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GEODGE	E WASHINGTON HEALTH & REHABILITATION		1510 COLLINGWOOD ROAD	
GEORGE	E WASHINGTON HEALTH & REHABILITATION		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	(EACH CORRECTIVE ACTION SHOULD BE COM	(X5) PLETION DATE
F 609	Continued From page 7	F 60	9	
	For Resident #1 (R1) the facility failed to report a right chest bruise of unknown origin, discovered 9/25/23, to the State Agency until 10/2/23.			
	On the quarterly MDS (minimum data set) with an ARD (assessment reference date) of 9/7/23, R1 was coded as being severely impaired for making daily decisions. She was coded as sometimes able to understand others, and as sometimes understanding others. She was admitted to the facility with a diagnosis of dementia.			
	A review of R1's care plan dated 4/5/22 and updated 10/12/23 revealed, in part: [R1] has difficulty communicating related to decline in cognitive status, lack/limited use/understanding of			
	English (fluent in Spanish)." A review of R1's clinical record revealed the following progress notes: "9/24/2023 09:30 (a.m.) Nursing Note Text: Resident noted this morning at 9:00 am shouting loud and speaking in Spanish language. Nurse went in to see what the problem is. Nurse noted resident in Geri-chair showing signs of discomfort and not allowing nurse to touch her left arm. Nurse immediately went in to call nursing supervisor and Spanish staff to help with interpretation of what resident was saying. She told staff that her left arm hurt and also want to go home to her familyAM (morning) prescribed meds given to resident and PRN (as needed) pain med given as well to help with painSitting at nurses' station at the moment with nurse for supervision. All safety measures maintained." This note was written by LPN (licensed practical nurse) #1, who was unavailable for interview during the survey.			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
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	PROVIDER OR SUPPLIER E WASHINGTON HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 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
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
	initiated the investigation into the injury of unknown origin. Resident continues with ongoing pain management regimen and MD notified." On 11/2/23 at 9:05 a.m., ASM #3, the attending physician, was interviewed. He stated on 9/25/23, a nurse told him about R1's bruising on her right			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COMPL	E SURVEY ETED
		495011	B. WIN	IG		11/	C 01/2023
	PROVIDER OR SUPPLIER E WASHINGTON HEALTH	H & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 609	of a line under the a He stated when he resident did not exh tenderness or pain. the course of his ph not suspect the resident signs of such an injustification of the stated she did not signs of such an injustification of the stated she did not signs of such an injustification of the stated she did not signs of such an injustification of the stated she did not signs of such an injustification of the stated she did not signs of such an injustification of the stated interviewed. ASM #1 the assistant did interviewed. ASM #1 were out of week of September first report of the brurecord. ASM #4 stated identify which staff in allegedly involved in those staff members suspended pending investigation. ASM #1 staff identified that the agency was not time correction in place. A review of the facility reported the lack of timely reagency revealed in part, "At facility reported the 10.2.23 when the Nadministrator) and was (sic) made awafailed to report timel noted by the nurse of the state of the state of the state of timely reagency revealed in part, "At facility reported the 10.2.23 when the Nadministrator) and was (sic) made awafailed to report timel noted by the nurse of the state of the sta	bruising was in somewhat armpit along the chest wall. touched the area, the hibit any expression of He stated at the time, in ysical assessment, he did dent had a shoulder injury. Tot display any physical ary on 9/25/23. If a.m., ASM (administrative the administrator, ASM #2, ng, ASM #4, the regional and RN (registered nurse) rector of nursing, were the stated he came to the the investigation of the ASM #2 stated she and the facility on vacation the 24 and 25, 2023, when the lise appeared in the edit took some time to members may have been at the injury to R1, and when is were identified, they were the results of the the report to the state liely, and they put a plan of the injury of unknown origin on altha (nursing home) DON (director of nursing) are of the injury. The facility by when the injury was first on 9/24/23All residents of k to be affected by this	F6	609			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	(X3) DAT COMPLI	E SURVEY ETED
		495011	B. WIN	G		11/	C 01/2023
	PROVIDER OR SUPPLIER E WASHINGTON HEALTH	1 & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 609	residents that are in BIMS (brief intervie of 8 (eight) or higher residents, skin assecompleted, assessir symptoms of abuse identified areas will the facility abuse and the facility will be reabuse and neglect focus on types of all investigations, and unknown origin. The provide abuse and reacility leadership or add this education to orientation. No staff return to work until thas been complete an adhoc QAPI (quiperformance improvationally) and the weekly audits with the QAPI committee committee is resport monitoring of compliance The complete abuse quesample of three resist the weekly audits with equal to the weekly audits wit	rairie will be completed on terviewable and have a w for mental status) score er. For non-interviewable essments will be ag for any signs orAny be addressed according to d neglect policyAll staff of educated on the facility policy. This education will buse, abuse reporting, reporting of injuries of e. Regional Nurse will neglect training to the an 10/9/23. The facility will conew hire members will be allowed to the mandatory education dThe facility will conduct ality assurance evement) meeting on and approve the allegation facility social worker will estionnaires on a random dents weekly. Results of all be submitted monthly to the monthly. The QAPI estible for the ongoing fanceDate of compliance: "ty policy, "Abuse eporting," revealed, in part: ent abuse, neglect, resident property, injuries of unknown origin	F 6	09			

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495011 B. WING 11/01/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD **GEORGE WASHINGTON HEALTH & REHABILITATION ALEXANDRIA, VA 22308** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ΙD PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) Continued From page 11 F 609 F 609 violation of...injuries of unknown source...will be reported immediately, but not later that...two hours if the alleged violation involves abuse or has resulted in serious bodily injury...or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury." The facility presented credible evidence that this plan of correction had been implemented. This credible evidence included staff education modules, interviews with staff, review of facility audits, and opportunities for facility reports to the state agency since the allegation of compliance date of 10/9/23. No concerns were identified with the implementation of the plan of correction. No further concerns regarding timely reporting to the State Agency was identified during the survey. F 656 F 656 SS=D No further information was provided prior to exit. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial

well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that

would otherwise be required

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	PROVIDER OR SUPPLIER E WASHINGTON HEALTH	1 & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
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F 656	not provided due to of rights under §48: to refuse treatment (iii) Any specialized specialized rehabili nursing facility will passage recommendations. If the findings of the fits rationale in the resident's represent (iv) In consultation with the resident's represent (A) The resident's good desired outcomes. (B) The resident's properties for future discharged document whether the resident community was assent to local contact age appropriate entities (C) Discharge plans care plan, as appropriate entities (C) of this section. §483.21(b)(3) The sarranged by the fact comprehensive car (iii) Be culturally-contrauma-informed. The met as evidenced be Based on observating document review, and the facility staff failed comprehensive car residents in the survent.	the resident's exercise 3.10, including the right under §483.10(c)(6). services or tative services the provide as a result of f a facility disagrees with PASARR, it must indicate esident's medical record. ith the resident and sentative(s)- poals for admission and reference and potential e. Facilities must t's desire to return to the essed and any referrals encies and/or other encies and/or other for this purpose. in the comprehensive priate, in accordance ents set forth in paragraph ervices provided or cility, as outlined by the e plan, must- enpetent and his REQUIREMENT is not his record review, and clinical record review, and to develop a e plan for one of five ey sample, Resident #4.	F 6	56	1. The comprehensive care plan was reand updated on November 1, 2023, to resident's #4 language preference. 2. All new admissions with a language to or that require a communication device the potential to be affected by this deficipractice. The facility will conduct an auc comprehensive care assessments to vathat all resident needs are met. 3. Licensed nursing staff of the facility will provided education on the facility policy comprehensive care plan. 4. The Director of Nursing/designee will perform audits of up to three comprehencare plans assessments each week for weeks to validate that care plans are addressing all the resident needs. Result he weekly audits will be reported month the QAPI committee x 3 months. The Committee is responsible for on-going monitoring of compliance. 5. Date of Compliance: December 04, 2	parrier have ient dit on alidate vill be for nsive eight alts of ally to DAPI	12/04/23

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495011 B. WING 11/01/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD **GEORGE WASHINGTON HEALTH & REHABILITATION ALEXANDRIA, VA 22308** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ΙD PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 13 F 656 F 656 develop a care plan to address her language needs. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/12/23, R4 was coded as being severely impaired for making daily decisions. She was coded as rarely understanding others and as rarely being understood by others for communication. On 11/1/23 at 11:46 a.m., R4 was observed as she was transferred from her bed to a wheelchair by way of a mechanical lift. Throughout the transfer process, the facility staff used a Russian translator, present through an iPad, to communicate with the resident. A review of R4's admission nursing assessment dated 10/6/23 revealed, in part: "Preferred language: Other...Other language: Russian." A review of R4's comprehensive care plan dated 10/22/23 revealed no evidence of interventions related to the resident's language barrier or need for communication devices. On 11/1/23 at 12:23 p.m., RN (registered nurse) #2, the MDS coordinator, was interviewed. When asked the process for developing a resident's comprehensive care plan, she stated: "I review the hospital records, the notes in [the electronic medical software] and doctor's notes." She stated she visits the resident, as well. When asked if a

resident's preference for a language other than English should be included in the care plan, she stated it should. After reviewing R4's comprehensive care plan, she stated it had not included the resident's preference for speaking

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
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	PROVIDER OR SUPPLIER	1 & REHABILITATION	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
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F 684 SS=D	staff member) #1, the the director of nursi regional nurse const these concerns. A review of the facility Comprehensive Perevealed, in part: "A comprehensive care measurable objective meet the resident's reasonable efforts with the resident's personable efforts with the resident's exit. Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of a resident of a resident end accordance standards of practice, the compreperson-centered caresidents' choices. This REQUIREMEN evidenced by: Based on staff interreview, and clinical resident's hospice personable efforts with the resident end accordance standards of practice, the compreperson-centered caresidents' choices. This REQUIREMEN evidenced by: Based on staff interreview, and clinical resident's hospice personable efforts with the resident end	ched for a translator. D.m., ASM (administrative the administrator, ASM #2, ng, and ASM #4, the sultant were informed of the policy, "Care Planning the preson-Centered," a person-centered the plan that includes the plan that includes the sand timetables to medical, apsychosocial needs shall the properties of the pro	F 6	DEFICIENCY)		
	residents in the					

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COMPLE	
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F 684	communicate with the provider regarding obtained on 9/29/23 A review of R1's clin the following progres "9/24/2023 09:30 (a Resident noted this shouting loud and slanguage. Nurse we problem is. Nurse neshowing signs of dis nurse to touch her lewent in to call nursir supervisor and Spall interpretation of what told staff that her lef go home to her fam prescribed meds gi (as needed) pain moment with nurse measures maintaine by LPN (licensed prunavailable for inter "9/25/2023 13:44 (1 (nurse practitioner) Complaint: follow up chest wall bruising. resident in here and wall bruising notice on bed, not in distres 1. Contusion of right	ident #1. i. i. i. i. i. i. i. i. i.	F 6	84	1. The facility staff followed up with the hospice provider on 10/02/23 when the was in receipt of the x-ray results. 2. Residents that utilize hospice service have orders for an imaging may be affe this deficient practice. The facility audite hospice resident's clinical records to valthat imaging results were received and reviewed. 3. Licensed nurses were educated on the facility policy for radiology and diagnost services and communication with hospic providers. 4. The Director of Nursing/designee will weekly for eight weeks audit hospice importers to validate that communication between facility and hospice providers. Results of the weekly audits will be reported to the QAPI committee x 3 more The QAPI committee is responsible for on-going monitoring of compliance. 5. Date of Compliance: December 04, 2	s and cted by ed idate ne ic ce aging orted ths.	12/04/23

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F 684	Origin." "9/25/2023 15:11 (3) Patient was seen by this afternoon, head the MD on unknown (at) the right arm of the preceived @ this time to monitor. RP (respondified." "9/29/2023 21:22 (9) Text: X-ray tech arm order to do arial vie [name of hospice provider to the transport of the transport o	:01 p.m.) Skin y (Licensed Nurse) kin observation o right arm. Unknown :11 p.m.) Nursing Note Text: y the visiting MD (physician) to toe assessment done by n origin of bruises noted @ patient, no new order e, nursing will continue consible party) :22 p.m.) Nursing Note ived to the unit for an w of the right humerus by rovider] pending result." y result for R1 dated m. revealed, in part: cture is seen but there is a umeral head (shoulder)." :13 p.m.) Alert Note [name of hospice late as to why they y to do an x-ray on the t communicating this to e could not give an answer am. Patient has a bruise of I a dislocation of the right	F6	884			
		TREATMENT for					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		LE CONSTRUCTION	(X3) DAT	E SURVEY ETED
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F 684	the facility between member) #2, the dir (registered nurse) # manager, who was during the survey. A interview document part: "On 9/29/23[(licensed practical number of the hume 10/1. She received it called the physician available for interview On 11/2/23 at 9:05 and physician, was inter 9/25/23, a nurse to loon her right side. How somewhat of a line chest wall. He states area, the resident diexpression of tende the time, in the cour assessment, he did had a shoulder injure display any physician sylvasical staff member) #1, the director of nursing nurse consultant, and #1, the assistant dir interviewed. ASM # facility to help with the director of the brunce of September first report of the brunce of ASM #1 were out of week of September first report of the brunce of ASM #2 staff.	ASM (administrative staff ector of nursing) and RN 3, the hospice case not available for interview A review of the facility dated 10/3/23 revealed, in RN #3] informed [LPN urse) #1] that she was y [for R1] to rule out erusRN #3 was off 9/30 - the results on 10/2/23 and the stated on the dim about R1's bruising estated the bruising was in under the armpit along the the dim to exhibit any rices or pain. He stated at see of his physical not suspect the resident ry. He stated she did not all signs of such an injury on a.m., ASM (administrative estated he came to the dim to the	F 6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 777 SS=D	expressed her frustration at the lact the X-ray results. Sobtained on a Fridacase manager was following Monday is ultimately responsible for a responsible f	10/2/23 when she tion. She stated she tion. She stated she thospice provider and the hospice provider and the stated the X-ray was any night, and the hospice not on duty again until the norning. When asked who sident's care, even when ASM #2 stated: "We are." ide evidence that the dup on the results of an dibeen obtained on dibeen obtained on dibeen obtained on dibeen with the hospice on was provided prior to provide provided prior to provide provided prior to prior to provided prior to provided prior to prior to prior to prior to prior to prior	F 6				

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F 777	review, and clinical r staff failed to obtain for one of five resident Resident #1. The findings include For Resident #1 (R1 to obtain timely resident was performed on 9/29/2 On the quarterly ME an ARD (assessme 9/7/23, R1 was codimpaired for making coded as sometimes others, and as some others. She was addiagnosis of dement A review of R1's club updated 10/12/23 difficulty communic cognitive status, lact of English (fluent in Sp. A review of R1's clin the following progres "9/24/2023 09:30 (a Resident noted this shouting loud and salanguage. Nurse we problem is. Nurse no showing signs of dis nurse to touch her lewent in to call nursir supervisor and Span interpretation of what	view, facility document record review, the facility timely results of an X-ray rents in the survey sample, i. (a), the facility staff failed record review that the survey sample, ii. (b), the facility staff failed record revealed revealed, in part: [R1] has reating related to decline in rek/limited use/understanding related to decline in rek/limited use/understanding related to decline in record revealed resonates: iii. (a) Nursing Note Text: morning at 9:00 am repeaking in Spanish rent in to see what the record resident in Geri-chair recomfort and not allowing reft arm. Nurse immediately regulated to help with resident was saying. She that arm hurt and also want to	F 7	77	 The facility reviewed the x-ray results 10/02/2023. Residents that utilize hospice service have orders for imaging may be affected this deficient practice. The facility audite hospice records to validate that imaging results are received and reviewed timely. Licensed nurses were educated on the facility policy for radiology and diagnost services and timely follow up of imaging results. The Director of Nursing/designee will weekly for eight weeks audit hospice im orders to validate timely follow up of resident to the weekly audits will be reported to the QAPI committee x 3 more The QAPI committee is responsible for on-going monitoring of compliance. Date of Compliance: December 04, 2 	es and d by ed y y ne ic g naging sults. orted oths.	12/04/23

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F 777	pain med given as we painSitting at nurs with nurse for super measures maintained by LPN (licensed prowas unavailable for survey. "9/25/2023 13:44 (1 (nurse practitioner) I Complaint: follow up chest wall bruising resident in here and wall bruising notice on bed, not in distred 1. Contusion of right under rt axillaclose prn." "9/25/2023 14:01 (2 Observation Weekly Note Text: Weekly secompleted. Bruise to Origin." "9/25/2023 15:11 (3 Patient was seen by this afternoon, head the MD on unknown (at) the right arm of the preceived @ this time to monitor. RP (respontified." "9/29/2023 21:22 (9 Text: X-ray tech armorder to do arial vie	ent and PRN (as needed) vell to help with ses' station at the moment rvision. All safety ed." This note was written actical nurse) #1, who interview during the 244 p.m.) Physician/NP Progress Note Text: Chief o; c/o (complaint of) rt (right) Patient is long term d follow up for c/o rt chest d by aide. pt (patient) lying essAssessment / Plan t chest wall - rt chest wall e observation, follow up 201 p.m.) Skin y (Licensed Nurse) kin observation o right arm. Unknown 211 p.m.) Nursing Note Text: y the visiting MD (physician) to toe assessment done by n origin of bruises noted @ 222 p.m.) Nursing Note even to the unit for an w of the right humerus by rovider] pending result." y result for R1 dated	F7	77			

"FINDINGS: No fracture is seen but there is a dislocation of the		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 777	patient and was no writer. On call nurse will follow up in the unknown origin and humeral head (protinferiorly)." "10/3/2023 09:45 (a Note Text: New order patient to Hospital FEVALUATION AND dislocation of the Humer of the facility between member) #2, the direct (registered nurse) # manager, who was during the survey. A interview document part: "On 9/29/23[(licensed practical in going to get an X-rafracture of the humer 10/1. She received a called the physician available for interview on 11/2/23 at 9:05 a physician, was inter 9/25/23, a nurse to on her right side. H	ilder)." ita p.m.) Alert Note [name of hospice pate as to why they y to do an x-ray on the it communicating this to e could not give an answer am. Patient has a bruise of Ita dislocation of the right bably anteriorly and i.m.) Change of Condition er received to transfer out OR FURTHER TREATMENT for imeral head." iview was documented by ASM (administrative staff ector of nursing) and RN 3, the hospice case not available for interview A review of the facility dated 10/3/23 revealed, in RN #3] informed [LPN urse) #1] that she was y [for R1] to rule out erusRN #3 was off 9/30 - the results on 10/2/23 and	F 777			

chest wall. He stated when he touched the area, the resident did not exhibit any expression of tenderness or pain.			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 777	Continued From page 22	F 777	
	He stated at the time, in the course of his physical assessment, he did not suspect the resident had a shoulder injury. He stated she did not display any physical signs of such an injury on 9/25/23.		
	On 11/1/23 at 10:39 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional nurse consultant, and RN (registered nurse) #1, the assistant director of nursing, were interviewed. ASM #4 stated he came to the facility to help with the investigation of the resident's bruising. ASM #2 stated she and ASM #1 were out of the facility on vacation the week of September 24 and 25, 2023, when the first report of the bruise appeared in the record. ASM #2 stated the hospice provider ordered the resident's X-ray, and she discovered the lag between the X-ray and the facility's notification of the results when she returned from vacation on 10/2/23. She stated the X-ray was obtained on a Friday night, and the hospice case manager was not on duty again until the following Monday morning. When asked who is ultimately responsible for a resident's care, even when hospice is involved, ASM #2 stated: "We are." When asked to provide evidence that the facility staff followed up on the results of an X-ray they knew had been obtained on 9/29/23, ASM #2 and ASM #4 stated they did not have any such evidence.		
	A review of the facility policy, "Radiology and Diagnostic Services," revealed, in part: "The facility will promptly notify the ordering physician/practitioner of diagnostic results that		
	fall outside of clinical reference rangesThe facility in collaboration with the physician/practitioner will establish means of communication and time frames for notification of diagnostic test results."		

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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 777	Continued From page 23	F 777		
F 842 SS=D	No further information was provided prior to exit. Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		
	§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and			
	(iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		, ,		(X3) DATE SURVEY COMPLETED
	495011			C 11/01/2023		
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 24 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; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one of five residents in the survey sample, Resident #2. The findings include:	F 842	1. The clinical record was update with a note from the psychiatrist for resident #2. 2. All residents can be affected by this deficient practice. 3. Licensed nurses were educated on the facility policy on charting and documentation to ensure that resident records are complete and accurate. 4. The Director of Nursing/designee will audit three clinical records weekly for eight weeks to validate that clinical records are complete and accurate. Results of the weekly audits will be reported monthly to the QAPI committee x 3 months. The QAPI committee is responsible for on-going monitoring of compliance. 5. Date of Compliance:December 04, 2023	12/04/23

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 11/01/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GEORGE WASHINGTON HEALTH & REHARII ITATION		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 25	F 842		
	For Resident #2 (R2), the facility staff failed to document in the clinical record, the findings of the Resident's report of a request for an unwanted sexual act.			
	Review of facility synopsis of events submitted to the state agency dated 5/17/23 revealed R2 made an allegation of an unsolicited sexual act. Review of the facility synopsis of events revealed, in part: "Resident made an allegation at			
	approximately 7:00 am that a white male entered her room and stated, 'Can you suck my			
	[expletive].' The resident denies being touched inappropriately and participating in any sexual activity. Resident was unable to identify the accused when presented with four random male choices."			
	Further review of clinical record failed to reveal progress notes regarding the incident.			
	On 11/1/23 at 8:45 a.m., ASM (Administrative Staff Member) #1, the administrator, was			
	interviewed. She stated that she took the resident statement when R2 voiced the issue. She stated that she asked various questions and followed up in the chart. She stated that the resident's			
	allegation would be documented in the progress notes. At 10:48 a.m., she added, "We have missed an opportunity to document. We do not see anything in the record."			
	On 11/1/23 at 10:48 a.m., an interview was conducted with ASM#3, Regional Nurse			
	Consultant. He stated, "Nothing recorded in medical record outside of psych visit."			
	On 11/01/23 at 10:49 a.m., ASM#1 and ASM#2			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	495011	B. WING	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER GEORGE WASHINGTON HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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 26 (Director of Nursing), ASM#3 were made aware of above concern.	F 842	2		
	A review of the facility policy, "Charting and Documentation," revealed, in part: "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, will be documented in the resident's medical record."				
	No further information was provided prior to exit.				