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 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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 10/31/23 through 11/1/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey (VA00059865 - substantiated with deficiencies). The census in this 96 certified bed facility was 94 at the time of the survey. The survey sample consisted of five current resident reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of	F 607		

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.

PRINTED: 11/14/2023 FORM APPROVED

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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:	F 607	Past noncompliance: no plan of correction required.	

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F 607	Continued From page 2 "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 family...AM (morning) prescribed meds given to resident and PRN (as needed) pain med given as well to help with pain...Sitting 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. "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 bruising...Patient 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 distress...Assessment / Plan 1. Contusion of right chest wall - rt chest wall under rt axilla...close observation, follow up prn." "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." "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	F 607		

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F 607	Continued From page 3 received @ this time, nursing will continue to monitor. RP (responsible party) notified." A review of the facility synopsis of events dated 10/2/23 revealed, in part: "Report date 10/2/23...Incident date: unknown - 9/24/23 per progress note...Incident type...injury of unknown origin...Describe incident...The Director of Nursing was informed on 10/2 of x-ray results taken on 9/29 for a dislocation of the humeral head for resident [#1]...Facility has initiated the investigation into the injury of unknown origin. Resident continues with ongoing pain management regimen and MD notified." A review of the facility policy, "Abuse Investigation and Reporting," revealed, in part: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown origin re thoroughly investigated by facility management...All violations involving...injuries of unknown source...will be reported by the facility administrator, or his/her designee...to the state licensing/certification agency...An alleged 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." 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.	F 607		

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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 Neglect...The 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 9/24/23...All residents of the facility are at risk to be affected by this 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,	F 607		

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F 607	Continued From page 5 skin assessments will be completed, assessing for any signs or symptoms of abuse...Any identified areas will be addressed according to the facility abuse and neglect policy...All staff of the facility will be reeducated on the facility abuse and neglect policy. This education will focus on types of abuse, abuse reporting, investigations, and reporting of injuries of unknown origin. The Regional Nurse will provide abuse and neglect training to the facility leadership on 10/9/23. The facility will add this education to new hire orientation. No staff members will be allowed to return to work until the mandatory education has been completed...The facility will conduct an adhoc QAPI (quality assurance performance improvement) meeting on 10/9/23 to review and approve the allegation of compliance...The facility social worker will complete abuse questionnaires on a random sample of three residents weekly. Results of the weekly audits will be submitted monthly to the QAPI committee monthly. The QAPI committee is responsible for the ongoing monitoring of compliance...Date of compliance: 10/9/23." 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 implementation of the abuse policy were identified during the survey. No further information was provided prior to exit. Reporting of Alleged Violations	F 607		
F 609 SS=D		F 609		

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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. The findings include:	F 609	Past noncompliance: no plan of correction required.	

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F 609	Continued From page 7 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 family...AM (morning) prescribed meds given to resident and PRN (as needed) pain med given as well to help with pain...Sitting 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.	F 609		

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F 609	Continued From page 8 "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 bruising...Patient 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 distress...Assessment / Plan 1. Contusion of right chest wall - rt chest wall under rt axilla...close observation, follow up prn." "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." "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 received @ this time, nursing will continue to monitor. RP (responsible party) notified." A review of the facility synopsis of events dated 10/2/23 revealed, in part: "Report date 10/2/23...Incident date: unknown - 9/24/23 per progress note...Incident type...injury of unknown origin...Describe incident...The Director of Nursing was informed on 10/2 of x-ray results taken on 9/29 for a dislocation of the humeral head for resident [#1]...Facility has 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	F 609		

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F 609	Continued From page 9 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. 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 Neglect...The 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 9/24/23...All residents of the facility are at risk to be affected by this deficient practice. Abuse	F 609		

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F 609	Continued From page 10 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, skin assessments will be completed, assessing for any signs or symptoms of abuse...Any identified areas will be addressed according to the facility abuse and neglect policy...All staff of the facility will be reeducated on the facility abuse and neglect policy. This education will focus on types of abuse, abuse reporting, investigations, and reporting of injuries of unknown origin. The Regional Nurse will provide abuse and neglect training to the facility leadership on 10/9/23. The facility will add this education to new hire orientation. No staff members will be allowed to return to work until the mandatory education has been completed...The facility will conduct an adhoc QAPI (quality assurance performance improvement) meeting on 10/9/23 to review and approve the allegation of compliance...The facility social worker will complete abuse questionnaires on a random sample of three residents weekly. Results of the weekly audits will be submitted monthly to the QAPI committee monthly. The QAPI committee is responsible for the ongoing monitoring of compliance...Date of compliance: 10/9/23." A review of the facility policy, "Abuse Investigation and Reporting," revealed, in part: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown origin re thoroughly investigated by facility management...All violations involving...injuries of unknown source...will be reported by the facility administrator, or his/her designee...to the state licensing/certification agency...An alleged	F 609		

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F 609	Continued From page 11 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 609		
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	F 656		

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F 656	Continued From page 12 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to develop a comprehensive care plan for one of five residents in the survey sample, Resident #4. The findings include: For Resident #4 (R4), the facility staff failed to	F 656	1. The comprehensive care plan was reviewed and updated on November 1, 2023, to reflect resident's #4 language preference. 2. All new admissions with a language barrier or that require a communication device have the potential to be affected by this deficient practice. The facility will conduct an audit on comprehensive care assessments to validate that all resident needs are met. 3. Licensed nursing staff of the facility will be provided education on the facility policy for comprehensive care plan. 4. The Director of Nursing/designee will perform audits of up to three comprehensive care plans assessments each week for eight weeks to validate that care plans are addressing all the resident needs. 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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F 656	Continued From page 13 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	F 656		

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	495011	A. BUILDING _____ B. WING _____	C 11/01/2023

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F 656	Continued From page 14 Russian, and the need for a translator. On 11/1/23 at 2:25 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were informed of these concerns. A review of the facility policy, "Care Planning - Comprehensive Person-Centered," revealed, in part: "A person-centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident...All reasonable efforts will be made to incorporate the resident's personal and cultural preferences in developing goals of care."	F 656		
F 684 SS=D	No further information was provided prior to exit. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to coordinate care with the resident's hospice provider for one of five residents in the	F 684		

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F 684	Continued From page 15 survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to communicate with the resident's hospice provider regarding the results of an X-ray obtained on 9/29/23. 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 family...AM (morning) prescribed meds given to resident and PRN (as needed) pain med given as well to help with pain...Sitting 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. "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 bruising...Patient 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 distress...Assessment / Plan 1. Contusion of right chest wall - rt chest wall under rt axilla...close observation, follow up prn."	F 684	1. The facility staff followed up with the hospice provider on 10/02/23 when the facility was in receipt of the x-ray results. 2. Residents that utilize hospice services and have orders for an imaging may be affected by this deficient practice. The facility audited hospice resident's clinical records to validate that imaging results were received and reviewed. 3. Licensed nurses were educated on the facility policy for radiology and diagnostic services and communication with hospice providers. 4. The Director of Nursing/designee will weekly for eight weeks audit hospice imaging orders to validate that communication between facility and hospice providers. 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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F 684	Continued From page 16 "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." "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 received @ this time, nursing will continue to monitor. RP (responsible party) notified." "9/29/2023 21:22 (9:22 p.m.) Nursing Note Text: X-ray tech arrived to the unit for an order to do arial view of the right humerus by [name of hospice provider] pending result." A review of the X-ray result for R1 dated 9/29/23 at 10:55 p.m. revealed, in part: "FINDINGS: No fracture is seen but there is a dislocation of the humeral head (shoulder)." "10/2/2023 18:13 (6:13 p.m.) Alert Note Text: Writer Called [name of hospice provider] to investigate as to why they used an outside contracting company to do an x-ray on the patient and was not communicating this to writer. On call nurse could not give an answer will follow up in the am. Patient has a bruise of unknown origin and a dislocation of the right humeral head (probably anteriorly and inferiorly)." "10/3/2023 09:45 (a.m.) Change of Condition Note Text: New order received to transfer out patient to Hospital FOR FURTHER EVALUATION AND TREATMENT for dislocation of the Humeral head."	F 684		

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F 684	Continued From page 17 On 10/3/23, an interview was documented by the facility between ASM (administrative staff member) #2, the director of nursing) and RN (registered nurse) #3, the hospice case manager, who was not available for interview during the survey. A review of the facility interview document dated 10/3/23 revealed, in part: "On 9/29/23...[RN #3] informed [LPN (licensed practical nurse) #1] that she was going to get an X-ray [for R1] to rule out fracture of the humerus...RN #3 was off 9/30 - 10/1. She received the results on 10/2/23 and called the physician." (LPN #1 was not available for interview during the survey). 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. 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 she discovered the lack of communication between the facility and	F 684		

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F 684	Continued From page 18 hospice provider on 10/2/23 when she returned from vacation. She stated she followed up with the hospice provider and expressed her frustration at the lack of communication about the X-ray results. 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, "Hospice Services," revealed, in part: "The facility will communicate and collaborate with the hospice provider."	F 684		
F 777 SS=D	No further information was provided prior to exit. Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by:	F 777		

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F 777	Continued From page 19 Based on staff interview, facility document review, and clinical record review, the facility staff failed to obtain timely results of an X-ray for one of five residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to obtain timely results of an X-ray that was performed on 9/29/23. 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 family...AM (morning) prescribed	F 777	1. The facility reviewed the x-ray results on 10/02/2023. 2. Residents that utilize hospice services and have orders for imaging may be affected by this deficient practice. The facility audited hospice records to validate that imaging results are received and reviewed timely. 3. Licensed nurses were educated on the facility policy for radiology and diagnostic services and timely follow up of imaging results. 4. The Director of Nursing/designee will weekly for eight weeks audit hospice imaging orders to validate timely follow up of results. 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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F 777	Continued From page 20	F 777		

meds given to resident and PRN (as needed) pain med given as well to help with pain...Sitting 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.

"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 bruising...Patient 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 distress...Assessment / Plan 1. Contusion of right chest wall - rt chest wall under rt axilla...close observation, follow up prn."

"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."

"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 received @ this time, nursing will continue to monitor. RP (responsible party) notified."

"9/29/2023 21:22 (9:22 p.m.) Nursing Note Text: X-ray tech arrived to the unit for an order to do arial view of the right humerus by [name of hospice provider] pending result."

A review of the X-ray result for R1 dated 9/29/23 at 10:55 p.m. revealed, in part:

	"FINDINGS: No fracture is seen but there is a dislocation of the			

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F 777	Continued From page 21 humeral head (shoulder)." "10/2/2023 18:13 (6:13 p.m.) Alert Note Text: Writer Called [name of hospice provider] to investigate as to why they used an outside contracting company to do an x-ray on the patient and was not communicating this to writer. On call nurse could not give an answer will follow up in the am. Patient has a bruise of unknown origin and a dislocation of the right humeral head (probably anteriorly and inferiorly)." "10/3/2023 09:45 (a.m.) Change of Condition Note Text: New order received to transfer out patient to Hospital FOR FURTHER EVALUATION AND TREATMENT for dislocation of the Humeral head." On 10/3/23, an interview was documented by the facility between ASM (administrative staff member) #2, the director of nursing) and RN (registered nurse) #3, the hospice case manager, who was not available for interview during the survey. A review of the facility interview document dated 10/3/23 revealed, in part: "On 9/29/23...[RN #3] informed [LPN (licensed practical nurse) #1] that she was going to get an X-ray [for R1] to rule out fracture of the humerus...RN #3 was off 9/30 - 10/1. She received the results on 10/2/23 and called the physician." (LPN #1 was not available for interview during the survey). 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	F 777		

	chest wall. He stated when he touched the area, the resident did not exhibit any expression of tenderness or pain.			

PRINTED: 11/14/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

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F 777	Continued From page 22 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 ranges...The facility in collaboration with the physician/practitioner will establish means of communication and time frames for notification of diagnostic test results."	F 777		

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

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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; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on 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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	495011	A. BUILDING _____ 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
F 842	Continued From page 25 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	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 26 (Director of Nursing), ASM#3 were made aware of above concern. 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.	F 842		