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	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
George Washington Health & Rehabilitation	1510 Collingwood Road Alexandria, VA 22308

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 27660 Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain dignity during a dressing change for one of seven residents in the survey sample, Resident #6. The findings include: For Resident #6 (R6), the facility staff failed to maintain dignity for the resident while performing wound care. Observation was made on 8/14/24 at 10:55 a.m. of LPN (licensed practical nurse) #1 performing wound care to R6's left hip wound. LPN #1 performed the wound care. After putting on the dressing, LPN #1 took a pen and wrote on the dressing, while on the resident, the date and her initials on the dressing. An interview was conducted on 8/14/24 at 3:40 p.m. with LPN #1. When asked if you should write on a resident's dressing after it is applied to the resident's hip, LPN #1 stated, she has to put a date on it, but she wasn't sure if you could write on the dressing while it was on the resident. An interview was conducted on 8/14/24 at 3:56 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked if the nurse can write on a dressing, after applying it to the resident, ASM #2 stated, no. When asked why, ASM #2 stated, it's a dignity concern. The facility policy, Dignity, documented in part, POLICY: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. DEFINITIONS: Dignity: is the right of a person to be valued and respected for their own sake, and to be treated ethically. SPECIFIC PROCEDURES / GUIDANCE: 1. Residents will be treated with dignity and respect at all times. The facility policy, Clean Dressing, documented in part, 19. Apply the ordered dressing and secure with tape or bordered dressing per order. Label with date and initials to top of dressing prior to placing on resident. ASM #1, the administrator, ASM #2, and ASM 33, the regional director of clinical operations, were made aware of the above findings, on 8/15/24 at approximately 11:30 a.m. (continued on next page)

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

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 27660 2. For Resident #3 (R3) the facility staff failed to implement the comprehensive care plan for the treatment of pressure injuries. The comprehensive care plan dated 6/11/24, documented in part, Focus: (R3) has actual impairment to skin integrity r/t (related to) admitted with sacrum wound, left ankle, right hip and right shoulder. The Interventions dated 6/11/24, documented in part, Administer medications, supplements and treatments as ordered. The Admission Assessment, dated 6/11/24, documented the following skin concerns: 1. Right trochanter (hip) - Pressure - 4 cm (centimeters) in length - 2.5 cm in width - no depth documented; no stage documented. 2. Left ankle (outer) - Pressure - 4 cm in length - 2.5 cm in width - no depth documented; no stage documented. 3. Sacrum - Pressure - 11.5 cm in length - 9 cm in width - 0.5 cm in depth - no stage documented. 4. Right shoulder (front)- Pressure - 1 cm in length - 1 cm in width - no depth documented - no stage documented. Review of the physician orders failed to evidence physician orders for the treatment of the above wounds until 6/14/24. The physician orders dated 6/14/24, documented: 1. Cleanse right hip with normal saline. Pat Dry. Apply Calcium Alginate to wound bed F/B (followed by) gauze island dressing. Change daily on 7-3 shift. 2. Cleanse left ankle with normal saline. Pat Dry. Apply Calcium Alginate to wound bed F/B (followed by) gauze island dressing. Change daily on 7-3 shift. 3. Cleanse sacral wound with normal saline. Pat Dry. Apply Calcium Alginate to wound bed F/B clean dry dressing daily on 7-3 shift. 4. Cleanse right shoulder with normal saline. Pat Dry. Apply Calcium Alginate to wound bed F/B gauze island dressing. change daily on 7-3 shift. A request was made for evidence of treatment for the above wounds from 6/11/24 until 6/14/24. On 8/15/24 at 9:45 a.m. ASM (administrative staff member) #3, the regional director of clinical operations stated there was no documented wound care from 6/11/24 through 6/13/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with LPN (licensed practical nurse) #1, on 8/15/24 at 11:32 a.m. When asked the purpose of the care plan, LPN #1 stated it's the plan of care for the resident. She stated they have to care plan everything, so we know how to take care of the resident. LPN #1 was asked if the care plan should be followed, LPN #1 stated, yes, we have to look at it all the time. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, were made aware of the above findings, on 8/15/24 at approximately 11:30 a.m. No further information was provided prior to exit. 3. For Resident #6 (R6), the facility staff failed to implement the comprehensive care plan for the treatment of pressure injuries. The comprehensive care plan dated, 6/2/24, documented in part, Focus: (R6) has wounds to sacrum, left ischium, left hip and abrasion to right buttock R/T (related to) immobility, generalized weakness, and ongoing disease process. The Interventions documented in part, Administer medications, supplements and treatments as ordered. The physician order dated, 6/12/24, documented, Cleanse left hip with Dakins solution, pat dry and apply Calcium Alginate to wound bed and cover with dry dressing daily. The physician order stated 6/12/24, documented, Cleanse left ischium with N/S (normal saline) pat dry and apply calcium alginate q (every) day until healed. The physician order dated, 6/12/24, documented, Cleanse stage 4 decub (decubitus ulcer - pressure injury) to sacrum with Dakins pat dry and apply calcium alginate dressing to wound bed and cover with dry dressing q day. Review of the June, July and August 2024, treatment administration record, failed to evidence the orders above. There was no documentation that the treatments had been completed from 6/12/24 through 8/13/24. An interview was conducted with LPN (licensed practical nurse) #1, on 8/15/24 at 11:32 a.m. When asked the purpose of the care plan, LPN #1 stated it's the plan of care for the resident. She stated they have to care plan everything, so we know how to take care of the resident. LPN #1 was asked if the care plan should be followed, LPN #1 stated, yes, we have to look at it all the time. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, were made aware of the above findings, on 8/15/24 at approximately 11:30 a.m. No further information was provided prior to exit. 49369 Based on observations, staff interview, facility document review, and clinical record review, the facility staff failed to follow comprehensive care plan for 2 of 7 sampled residents. The findings include: 1. For Resident #3 (R3), the facility staff failed to implement a comprehensive care plan regarding Transmission Based Precaution. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 2:40 p.m., an observation was made of staff members not wearing full personal protective equipment (PPE) when performing incontinence care on R3. A sign that indicated resident was on Enhanced Barrier Precautions was posted on the door and a bin with some PPE supplies were outside the door. LPN (licensed practical nurse) #2 was wearing a gown and gloves but did not have a mask. CNA (certified nursing assistant) #1 wore gloves but did not have a gown or mask on. At 2:55 p.m., CNA#1 exited R3's room without performing hand hygiene. A review of R3's physician's orders dated 6/25/24, revealed: Infection precautions-enhanced barrier precautions. A review of R3's clinical record, including the resident's comprehensive care plan revealed: The resident has the potential for infection on Enhanced barrier precaution r/t wounds. The resident will be free from complications related to infection through review date. Maintain universal precautions when providing resident care. On 8/13/24 at 2:58 p.m., CNA#1 was interviewed. She stated that she did not follow EBP precautions for the resident because she was in a rush. She stated that the care plan was not followed for the resident. On 8/15/24 at 10:41a.m., ASM (administrative staff member) #2 was interviewed. She stated that the purpose of the comprehensive care plan is to have a plan of care for the resident. She also stated that everyone is responsible for implementing the care plan. On 8/15/24 at 11:36 a.m., LPN #1 was interviewed. She stated that the purpose of the care plan is to be a point of care for the patients to know how to take care of the resident. She stated that it should be followed and looked at to confirm what should be done. On 8/15/24 at 11:56 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, a regional director of clinical operations, were informed of these concerns. A review of the facility policy, Care Planning-Comprehensive Person-Centered, revealed in part: The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process. No further information was provided prior to exit.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for one of seven residents in the survey sample, Resident #1. The findings include: For Resident #1, the facility staff failed to review and revise the comprehensive care plan after a fall on 8/1/23. The nurse's note dated 8/1/23 at 9:18 a.m. documented in part, Pt (patient) observed lying supine in bed with L (left) forehead hematoma with two dots of dried blood, no bleeding noted at this time. Pt is unable to tell staff whether he is in pain or not but is holding his forehead occasionally. Call placed out to (name of doctor)'s office and updated MD (medical doctor) on call (name of doctor). Order received from MD to transfer pt to (name of hospital) ER (emergency room) via 911 for further evaluation r/t (related to) L - forehead hematoma. Order noted and activated the Rescue Squad. Pt is picked up at 0925 (9:25 a.m.) and transported to (initials of hospital) ER. Family is updated. The comprehensive care plan dated, 7/19/23, documented in part, Fall: (R1) had actual fall and is at risk for further falls R/T (related to) Gait/balance problems, confusion, history of falls, generalized weakness. The Interventions dated 7/19/23, documented in part, Reinforce to call for assistance when needed. Be sure the resident's call light is within reach and encourage the resident to use it or assistance as needed. The resident needs prompt response to all requests for assistance. Pt (physical therapy) evaluate and treat as ordered or PRN (as needed). Anticipate and meet the resident's needs. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair). Encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Follow facility fall protocol. There was no documented review of the care plan, or any new interventions put in place after the fall of 8/1/23. An interview was conducted on 8/15/24 at 10:44 a.m. with ASM (administrative staff member) #3, the regional director of clinical operations. ASM #3 stated after he reviewed the clinical record, there was no revision made to the care plan after the fall of 8/1/23. An interview was conducted with LPN (licensed practical nurse) #1 on 8/15/24 at 11L32 a.m. When asked the purpose of the care plan, LPN #1 stated it's the plan of care for the patient. They have to care plan everything, so we know how to take care of the patient. LPN #1 was asked who updates the care plan, LPN #1 stated, nurses, all departments, it's everyone's responsibility. When asked if a resident has a fall, does the care plan get updated, LPNM #1 stated, yes, immediately to help prevent another fall. The facility policy, Care Planning - Comprehensive Person Centered, documented in part, 16. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: b. When there has been a significant change in the resident's condition. c. When the desired outcome is not met. d. When the goals, needs and preferences change. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, were made aware of the above findings, on 8/15/24 at approximately 11:30 a.m. No further information was provided prior to exit.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 27660 Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed provide care and services for the treatment of pressure injuries for two of seven residents in the survey sample, Residents #3 and #6. The findings include: 1.a. For Resident #3(R3), the facility staff failed to implement treatments for four pressure injuries upon admission on 6/11/24 until 6/14/24. The Admission Assessment, dated 6/11/24, documented the following skin concerns: 1. Right trochanter (hip) - Pressure - 4 cm (centimeters) in length - 2.5 cm in width - no depth documented; no stage documented. 2. Left ankle (outer) - Pressure - 4 cm in length - 2.5 cm in width - no depth documented; no stage documented. 3. Sacrum - Pressure - 11.5 cm in length - 9 cm in width - 0.5 cm in depth - no stage documented. 4. Right shoulder (front)- Pressure - 1 cm in length - 1 cm in width - no depth documented - no stage documented. Review of the physician orders failed to evidence physician orders for the treatment of the above wounds until 6/14/24. The physician orders dated 6/14/24, documented: 1. Cleanse right hip with normal saline. Pat Dry. Apply Calcium Alginate to wound bed F/B (followed by) gauze island dressing. Change daily on 7-3 shift. 2. Cleanse left ankle with normal saline. Pat Dry. Apply Calcium Alginate to wound bed F/B (followed by) gauze island dressing. Change daily on 7-3 shift. 3. Cleanse sacral wound with normal saline. Pat Dry. Apply Calcium Alginate to wound bed F/B clean dry dressing daily on 7-3 shift. 4. Cleanse right shoulder with normal saline. Pat Dry. Apply Calcium Alginate to wound bed F/B gauze island dressing. change daily on 7-3 shift. The wound care physician started following the resident's wounds on 6/18/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan dated 6/11/24, documented in part, Focus: (R3) has actual impairment to skin integrity r/t (related to) admitted with sacrum wound, left ankle, right hip and right shoulder. The Interventions dated 6/11/24, documented in part, Administer medications, supplements and treatments as ordered. A request was made for evidence of treatment for the above wounds from 6/11/24 until 6/14/24. On 8/15/24 at 9:45 a.m. ASM (administrative staff member) #3, the regional director of clinical operations stated there was no documented wound care from 6/11/24 through 6/13/24. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, were made aware of the above findings, on 8/15/24 at approximately 11:30 a.m. No further information was provided prior to exit. 1.b. For Resident #3, the facility staff failed to accurately document skin assessments. The Skin Observation Weekly dated 6/24/24, documented in part, 5. Are there any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? A No, was documented. 6. Additional information: Previous pressure ulcers to sacrum, treatment orders in place. The Skin Observation Weekly dated 7/22/24, documented in part, 5. Are there any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? A No, was documented. 6. Additional information: Resident continues to receive wound care exiting (sic) sacral wound ulcer, right figure (sic) and heels. No new skin issues noted. The Skin Observation Weekly dated 7/29/24, documented in part, 5. Are there any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? A Yes was documented. 5a. Select all that apply: Open area. Open Area Location: Other. Is this a NEW skin condition? No. 6. Additional Information: Treatments in place for areas of skin trauma. The Skin Observation Weekly dated 8/5/24, documented in part, 5. Are there any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? A No, was documented. 6. Additional information: Blank - nothing documented. The Skin Observation Weekly dated 8/12/24, documented in part, 5. Are there any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? A No, was documented. 6. Additional information: no new skin issues noted. An interview was conducted with LPN #1 on 8/14/24 at 3:40 p.m. When asked how often skin assessments are to be done, LPN #1 stated they are done every week on shower days. LPN #1 was asked what is to be documented, LPN #1 stated the nurse goes in and looks at the skin. They should document any new or old areas. She stated sometimes they write if it's an old wound that treatment is in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Pressure Injury Preventions and Management, documented in part, Identification: 1. Staff will be encouraged to promptly report any observation of a change in the resident's skin integrity. 2. Weekly skin observations will be conducted by a licensed nurse and findings will be documented in the resident's medical record. 3. Observations of new pressure ulcer/injury will be: a. Reported to the physician / practitioner for further evaluation and treatment. b. Referred to the designated wound nurse as appropriate. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, were made aware of the above findings, on 8/15/24 at approximately 11:30 a.m. No further information was provided prior to exit. 2a. For Resident #6 (R6), the facility staff failed to evidence documentation of treatment to the resident's pressure injuries from 6/12/24 through 8/14/24. The physician order dated, 6/12/24, documented, Cleanse left hip with Dakins solution, pat dry and apply Calcium Alginate to wound bed and cover with dry dressing daily. The physician order stated 6/12/24, documented, Cleanse left ischium with N/S (normal saline) pat dry and apply calcium alginate q (every) day until healed. The physician order dated, 6/12/24, documented, Cleanse stage 4 decub (decubitus ulcer - pressure injury) to sacrum with Dakins pat dry and apply calcium alginate dressing to wound bed and cover with dry dressing q day. Review of the June, July and August 2024, treatment administration record, failed to evidence the orders above. There was no documentation that the treatments had been completed from 6/12/24 through 8/13/24. Review of the wound care physician notes from 5/24/24 through 8/13/24, evidenced the wounds had decreased in size, indicating healing. The comprehensive care plan dated, 6/2/24, documented in part, Focus: (R6) has wounds to sacrum, left ischium, left hip and abrasion to right buttock R/T (related to) immobility, generalized weakness, and ongoing disease process. The Interventions documented in part, Administer medications, supplements and treatments as ordered. On 8/15/24 at 9:45 a.m. ASM (administrative staff member) #3, the regional director of clinical operations stated there was no documented wound care from 6/12/24 through 8/13/24. He stated that the order was not put in the computer correctly. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, were made aware of the above findings, on 8/15/24 at approximately 11:30 a.m. No further information was provided prior to exit. 2b. For Resident #6, the facility staff failed to accurately document skin assessments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Skin Observation Weekly dated 7/8/24, documented in part, 5. Are there any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? A yes, was documented. 5a. Select all that apply other. 5a6. Other - specify sacral wound. Additional information: Treatment ongoing. The Skin Observation Weekly dated 7/21/24, documented in part, 5. Are there any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? A yes, was documented. 5a. Select all that apply other. 5a6. Other - specify sacral wound. Additional information: Wound care provided; treatment ongoing. The Skin Observation Weekly dated 7/28/24, documented in part, 5. Are there any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? A No, was documented. 6. Additional information: none. The Skin Observation Weekly dated 8/4/24, documented in part, 5. Are there any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? A yes, was documented. 5a. Select all that apply open area. 5a6. Other - specify coccyx. Additional information: Treatment in progress. The Skin Observation Weekly dated 8/11/24, documented in part, 5. Are there any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? A yes, was documented. 5a. Select all that apply open area. 5a6. Other - specify coccyx. Additional information: Treatment being applied to open area. The comprehensive care plan dated, 7/6/24, documented in part, Focus: (R6) has wounds to sacrum, left ischium, left hip and abrasion to right buttock R/T (related to) immobility, generalized weakness, and ongoing disease process. The Interventions documented in part, Follow facility policies/protocols for routine skin monitoring. Report any changes to MD/NP (medical doctor/nurse practitioner). An interview was conducted with LPN #1 on 8/14/24 at 3:40 p.m. When asked how often skin assessments are to be done, LPN #1 stated they are done every week on shower days. LPN #1 was asked what is to be documented, LPN #1 stated the nurse goes in and looks at the skin. They should document any new or old areas. She stated sometimes they write if it's an old wound that treatment is in place. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, were made aware of the above findings, on 8/15/24 at approximately 11:30 a.m. No further information was provided prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 27660 3. For Resident #6(R6), the facility staff failed to implement infection control practices during a wound treatment. Observation was made of LPN (licensed practical nurse) #1, on 8/14/24 at 10:55 a.m. performing wound care for R6. The resident had three wounds accessible for wound care treatments, left ischium, right buttock, sacrum and an old scar on right hip. LPN #1 removed all the dressings in place. Changed her gloves. She proceeded to use the same gloves to clean each wound, starting with the right hip, went to buttock wound, ischium wound and then sacral wound, all with the same gloves on. LPN #1 didn't have gloves on and dried the right hip and buttock wound with dry gauze. She then put gloves on and wiped the sacral wound with a dry gauze. She proceeded to use dry gauze to dry the ischium and buttock wounds, using the same gloves. An interview was conducted with LPN #1 on 8/14/24 at 3:40 p.m. When asked if a resident has multiple wounds, do you treat each wound separately, taking off dressing, cleansing it, putting prescribed treatment in place, prior to moving on to the next wound, LPN #1 stated, yes. The above observation was shared with LPN #1. The facility policy, Clean Dressing, documented in part, POLICY: The purpose of this procedure is to provide guidelines for the application of clean dressings. DEFINITIONS: Clean technique involves strategies used in resident care to reduce the overall number of microorganisms or to prevent or reduce the risk of transmission of microorganisms from one person to another or from one place to another. Clean technique involves meticulous handwashing, maintaining a clean environment by preparing a clean field, using clean gloves and sterile instruments, and preventing direct contamination of materials and supplies. No 'sterile to sterile rules apply. ASM #1, the administrator, ASM #2, and ASM #3, the regional director of clinical operations, were made aware of the above findings, on 8/15/24 at approximately 11:30 a.m. No further information was provided prior to exit. 49369 Based on observations, staff interview, facility document review and clinical record review, the facility staff failed to implement an infection prevention & control program and failed to implement infection control practices for two of seven residents in the survey sample, Residents #3 and #6. The findings include: 1. The facility staff failed to provide infection control surveillance program evidence prior to June 2024. (continued on next page)

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	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
George Washington Health & Rehabilitation	1510 Collingwood Road Alexandria, VA 22308

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/15/24 at 10:41 a.m., ASM (administrative staff member) #2 was interviewed. She stated the facility is starting to track infection control on Point Click Care (PCC). She sated that they cannot produce evidence for infection tracking before June 2024. Infection control tracking after June 2024 is available on point click care. On 8/15/24 at 11:56 a.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, a regional director of clinical operations, were informed of these concerns. A review of the facility policy, Surveillance for Infections, revealed: The infection preventionist (designee) will conduct ongoing surveillance for healthcare-associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions. No further information was provided prior to exit. 2. For Resident #3, the facility staff failed to use PPE and handwashing in Transmission Based Precaution (TBP) room. On 8/16/24 at 2:40 p.m., an observation was made of staff members not wearing full personal protective equipment (PPE) when performing incontinence care on R3. A sign that indicated resident was on Enhanced Barrier Precautions (EBP) was posted on the door and a bin with some PPE supplies were outside the door. LPN (licensed practical nurse) #2 was wearing a gown and gloves but did not have a mask. CNA (certified nursing assistant) #1 wore gloves but did not have a gown or mask on. At 2:55 p.m., CNA#1 exited R3's room without performing hand hygiene. A review of R3's physician's orders dated 6/25/24, revealed: Infection precautions-enhanced barrier precautions. A review of R3's clinical record, including the resident's comprehensive care plan revealed: The resident has the potential for infection on Enhanced barrier precaution r/t wounds. The resident will be free from complications related to infection through review date. Maintain universal precautions when providing resident care. On 8/13/24 at 2:58 p.m., CNA#1 was interviewed. She stated that it is important to wash your hands before and after taking off gloves because it is a matter of infection control for the resident. She stated that it is important to perform hand hygiene when performing incontinence care especially if they are on EBP to get rid of bacteria. She stated that knows that it should have worn PPE and washed her hands but forgot to do so because she was in a rush. On 8/15/24 at 11:36 a.m., LPN#1 was interviewed. She stated that it is important to wash your hands to protect yourself and the resident. She also stated that hand hygiene is done as an infection control matter because hands can be a carrier to bacteria and germs. LPN1 stated when entering a room when someone is on EBP the staff should don/doff gown, gloves and mask as well as perform hand hygiene. On 8/15/24 at 11:56 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, a regional director of clinical operations, were informed of these concerns. (continued on next page)

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	08/15/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy, Enhanced Barrier Precautions (EBP) Policy, revealed: The purpose of this policy is to outline the guidelines for implementing Enhanced Barrier Precautions (EBP) in order to reduce the transmission of multidrug-resistant organism (MDROs) within our facility. EBP will be utilized in conjunction with standard precaution to provide targeted gown and glove use during high-contact resident care activities. EBP should be utilized during the following activities .changing briefs or assisting with toileting. A review of the facility policy, Hand hygiene, revealed: The facility promotes hand hygiene as a simple and effective method for preventing the spread of infections. Glove use is not a substitute for hand hygiene. All staff are to perform hand hygiene during all care activities and while working in all locations within the facility . All staff are responsible for following hand hygiene procedures . b. Before and after having direct contact with a resident's intact skin . f. Before and after wearing gloves .During Routine Resident Care a. Use an ABHR (alcohol-based hand sanitizer): i. immediately before touching a resident ii. Before performing an aseptic task . iii. Before moving from work on a soiled body site to a clean body site on the same resident iv. After touching a resident or the resident's immediate environment v. Immediately after removing gloves. No further information was provided during exit.