STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
August Healthcare at Leewood	7120 Braddock Road Annandale, VA 22003

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, document review, and facility policy review, the facility failed to implement their abuse policy and ensure one resident (Resident (R) 94) of one reviewed for abuse was safe after R94 sustained an injury during activity of daily living (ADL) care by a Certified Nurse Aide (CNA), and the facility did not investigate to rule out that abuse occurred out of a total sample of 33 residents. The facility's failure to ensure residents were free from physical abuse caused or was likely to cause serious injury, harm, impairment, or death to a resident. Cross reference F609 and F610.An Immediate Jeopardy was identified on 04/30/26 and was determined to exist on 03/10/25, in the area of S483.12 Freedom from Abuse, Neglect, and Exploitation at a Scope and Severity (S/S) of a J. The Administrator, Director of Nursing (DON), Regional Director of Clinical Services, and Regional Director of Operations were notified of the Immediate Jeopardy on 04/30/26 at 10:56 AM. Findings include: Review of R94's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses which included altered mental status. Review of R94's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 03/18/26 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated moderately impaired cognition. Further review revealed her preferred language was Korean. Review of R94's Care Plan, initiated on 12/17/25 and located under the Care Plan tab of the EMR, revealed . The resident will have no complications from discoloration. Further review revealed the care plan was not updated after R94 sustained injuries to her wrist on 03/20/25. During an interview on 04/29/26 at 10:30 AM, the Chief Executive Officer (CEO) stated it was not reported to the state survey agency (SSA), and they did not have an investigation for the incident that occurred on 03/20/25. The CEO stated they had a paper, and he would provide the paper. The CEO later provided the grievance form that he referred to as a paper. Review of facility provided Incident Report for Bruise, dated 03/20/25 at 9:45 PM and written by RN1 revealed, . Writer was informed by [CNA2] that resident developed discoloration of bilateral wrist during ADLS care when changing resident clothes [and the] resident was resisting care. Resident bumped bilateral wrist against the wheelchair during transfer. Discoloration and swelling were present. Further review revealed immediate action taken was assessed resident, resident asked to flex both hands for mobility, physician notified and ordered x-ray to rule out fracture. Per CNA2, the resident bumped wrists on wheelchair during the transfer and show [sic] bruising during the wheelchair transfer. CNA2 was removed from the assignment and immediately educated to stop providing care if a resident resists. CNA2 stated he would never intentionally harm a resident that she bumped arms [sic] rests during care. Three statements were provided to the survey team several (continued on next page)

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.

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
	495337	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
August Healthcare at Leewood	7120 Braddock Road Annandale, VA 22003

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hours later by CNA2, Registered Nurse (RN) 1 and CNA3. Review of the facility provided Employee Witness Statement, dated 03/20/25 and written by RN1 revealed, . He was informed that R94 was adamantly resisting care. During transfer, resident bumped her wrists against wheelchair causing discoloration. Ice bag was presented to mitigate pain, but resident still refused. Physician and resident representative were made aware of situation and ordered x-ray. Resident was interrogated but was unable to communicate coherent English. Review of the facility provided Employee Witness Statement, dated 03/20/25 and written by CNA2 revealed, . R94 hit arms down on wheelchair after transfer her back to wheelchair from toileting was going to transfer her back. Start hitting her arms up and down on wheelchair. I went to get CNA3 to attempt reapproach with another CNA. CNA2 return [sic] to her room. Return [sic] noticed discoloration to wrist area. Immediately notified charge nurse. Review of the facility provided Employee Witness Statement, dated 03/20/25 and written by CNA3 revealed, . I was asked to assist with R94. R94 was agitated in room. Her CNA got the nurse. The nurse assessed and called all the people he needed to notify. Review of R94's Nurse's Note, dated 03/20/25 at 11:35 PM written by Registered Nurse (RN) 1 and located under the Notes tab of the EMR, revealed, . Writer was informed by [CNA2] that resident developed discoloration of bilateral wrist after accident when changing clothes because patient was also resisting. Resident bilateral wrist was assessed. Discoloration and swelling were present. CNA was asked to get ice bag and apply them to affected areas for relief. During an interview 04/29/26 at 11:15 AM, CNA2 stated he was the assigned CNA to R94 during the 3-11 PM shift. At some point during that evening, he was getting R94 ready for bed. He first toileted R94 and then pushed her wheelchair to her bed and attempted to put her back to bed. He was standing in front of her, and he placed his arms under her armpit area and was trying to lift her, but he never actually lifted her out of the seat. CNA2 stated R94 resisted by lifting her arms above her waist, but she never swung them. He stated he asked her what happened and she just looked at him but did not scream. CNA2 stated he left R94's room and went and called a female CNA, CNA3 and they went back to the resident's room. They both put gloves on, and CNA3 attempted to lift R94, and then said Look. what is that? CNA2 stated it appeared to be a blistered area. He went and got RN1. RN1 came and asked what happened, and he told him he did not know. CNA2 said the nurse supervisor also came and asked him what happened. He told the supervisor that R94 was resisting, but he did not know how the injury happened. He said he applied ice to area, and he was still assigned to her for the rest of the shift. He thinks another CNA was assigned, but he was unsure who put R94 to bed. He was also unsure if he took her vitals. He stated he has been assigned to R94's unit and to her room, but he asked for another staff member to switch R94's room for another resident room. He said he was taken off the schedule for three days, and he was told the facility had to do their investigation. He stated to his knowledge the facility never figured out how R94 sustained the wrist injury. He confirmed the injury was not there prior to him attempting to put R94 to bed and transfer her out of the wheelchair. An interview was attempted on 04/29/26 at 11:51 AM with RN1 and was unsuccessful. A voice mail was left requesting a return call. During an interview on 04/29/26 at 12:01 PM, Family Member (FM) 1 stated R94 did not speak English. She stated she spoke with R94 about the incident that occurred on 03/20/25 and R94 told her she refused to be changed into the nightgown, and the staff grabbed her hand and tried to force her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
August Healthcare at Leewood	7120 Braddock Road Annandale, VA 22003

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She said it was a big black guy, but she did not know his name. FM1 stated she reported this allegation to a nurse and the prior Administrator. She stated a second incident happened on 06/29/25 in which R94 sustained wrist injuries after she refused to be changed into a nightgown by a big black male and that he held her hands down and tried to force her to allow him to change her. She stated she also reported it to adult protective services (APS) since the facility had not done an investigation into the allegation. During an interview on 04/29/26 at 2:43 PM, the Social Service Director (SSD) stated all reports of abuse were reported to the SSA within 24 hours. She stated during every investigation of abuse she would interview the resident and five other cognitive residents with a BIMS higher than 12 and complete a Trauma assessment. She stated she did not interview R94 about the abuse allegation/injury that occurred on 03/20/25, and she did not interview any other residents or complete a trauma assessment on R94. She stated the facility had a meeting and it was determined that abuse did not occur, but she was unsure how the facility came to that conclusion. She also stated she should have interviewed R94 and other residents about the 03/20/25 incident. During an interview on 04/29/26 at 3:35 PM, the Administrator stated she was the DON at the time of the incident on 03/20/25. She stated the facility should report all allegations of abuse/injury of unknown origin within two hours and immediately start an investigation. She stated they would interview all staff that worked with the resident in the last 72 hours or any staff that may have knowledge of the incident, the resident, and five other cognitive residents. She stated the incident that occurred on 03/20/25 was not reported because it was not an injury of unknown origin. She stated CNA2 self-reported that the injury occurred during care. She stated the facility determined that because CNA2 denied abuse and said it occurred during ADL care. She stated they only interviewed CNA2 and RN1. A review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 11/2021, revealed, . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse. neglect or exploitation occur. Written procedures for investigations include Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause and providing complete and thorough documentation of the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
August Healthcare at Leewood	7120 Braddock Road Annandale, VA 22003

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to report an allegation of potential abuse after Resident (R)94 sustained an injury during activity of daily living (ADL) care by a certified nurse aide (CNA) timely to the state survey agency for (SSA) for one of five residents (Resident (R) 94) reviewed for abuse out of 33 sampled residents. This had the potential to affect residents in the facility who were at risk for abuse. Cross reference F607 and F610.Findings Include: Review of R94's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses which included altered mental status. Review of facility provided Incident Report for Bruise, dated 03/20/25 at 9:45 PM and written by RN1, revealed, . Writer was informed by [CNA2] that resident developed discoloration of bilateral wrist during ADLS care when changing resident clothes [and the] resident was resisting care. Resident bumped bilateral wrist against the wheelchair during transfer. Discoloration and swelling were present. Further review revealed immediate action taken was assessed resident, resident asked to flex both hands for mobility, physician notified and ordered x-ray to rule out fracture. Review of R94's Nurse's Note, dated 03/20/25 at 11:35 PM, written by Registered Nurse (RN) 1 and located under the Notes tab of the EMR, revealed, . Writer was informed by [CNA2] that resident developed discoloration of bilateral wrist after accident when changing clothes because patient was also resisting. Resident bilateral wrist was assessed. Discoloration and swelling were present. CNA was asked to get ice bag and apply them to affected areas for relief. During an interview on 04/29/26 at 10:30 AM, the Chief Executive Officer (CEO) stated the incident that occurred on 03/20/25 was not reported to the SSA. During an interview on 04/29/26 at 3:35 PM, the Administrator stated she was the Director of Nursing (DON) at the time of the incident on 03/20/25. She stated the facility should report all allegations of abuse/injury of unknown origin within two hours. She confirmed this allegation was not reported to the SSA since they determined it was not an injury of unknown origin or abuse. Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 11/2021, revealed, . Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: 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 inju

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
August Healthcare at Leewood	7120 Braddock Road Annandale, VA 22003

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to investigate an allegation of potential abuse after one resident (Resident (R) 94) sustained an injury during activity of daily living (ADL) care by a certified nurse aide (CNA) for one of five residents (Resident (R) 94) reviewed for abuse out of 33 sampled residents. This had the potential to affect residents in the facility who were at risk for abuse. Cross reference F607 and F609. Findings Include: Review of R94's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses which included altered mental status. Review of R94's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 03/18/26 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated moderately impaired cognition. Further review revealed her preferred language was Korean. Review of R94's Care Plan, initiated on 12/17/25 and located under the Care Plan tab of the EMR, revealed, . The resident will have no complications from discoloration. Further review revealed the care plan was not updated after R94 sustained injuries to her wrist on 03/20/25. Review of facility Incident Report for Bruise, dated 03/20/25 at 9:45 PM, and written by RN1 revealed, . Writer was informed by [CNA2] that resident developed discoloration of bilateral wrist during ADLS care when changing resident clothes [and the] resident was resisting care. Resident bumped bilateral wrist against the wheelchair during transfer. Discoloration and swelling were present. Further review revealed immediate action taken was assessed resident, resident asked to flex both hands for mobility, physician notified and ordered x-ray to rule out fracture. Review of R94's Nurse's Note, dated 03/20/25 at 11:35 PM, written by Registered Nurse (RN) 1, and located under the Notes tab of the EMR, revealed, . Writer was informed by CNA2 that resident developed discoloration of bilateral wrist after accident when changing clothes because patient was also resisting. Resident bilateral wrist was assessed. Discoloration and swelling were present. CNA was asked to get ice bag and apply them to affected areas for relief. During an interview on 04/29/26 at 10:30 AM, the Chief Executive Officer (CEO) stated they did not have an investigation for the incident that occurred on 03/20/25. The CEO stated they had a paper, and he would provide the paper. The CEO provided a copy of the grievance that he previously referred to as the paper. During an interview on 04/29/26 at 12:01 PM, Family Member (FM) 1 stated on 03/20/25 R94 told her she refused to be changed into the nightgown, and the staff grabbed her hand and tried to force her. FM1 stated she reported this allegation to a nurse and the prior Administrator. During an interview on 04/29/26 at 2:43 PM, the Social Service Director (SSD) stated during every investigation of abuse she would interview the resident and five other cognitive residents with a BIMS higher than 12 and complete a Trauma assessment. She stated she did not interview R94 about the abuse allegation/injury that occurred on 03/20/25, and she did not interview any other residents or complete a trauma assessment on R94. She stated the facility had a meeting and it was determined that abuse did not occur. She was unsure how the facility came to that conclusion. She also stated she should have interviewed R94 and other residents about the 03/20/25 incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
August Healthcare at Leewood	7120 Braddock Road Annandale, VA 22003

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/29/26 at 3:35 PM, the Administrator stated she was the Director of Nursing (DON) at the time of the incident on 03/20/25. After all allegations of abuse, they immediately start an investigation. She stated CNA2 self-reported that the injury occurred during care. She stated the facility determined abuse did not occur because CNA2 denied abuse and said it occurred during ADL care. She stated they only interviewed CNA2 and RN1 and nobody else. A review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 11/2021, revealed, . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse. neglect or exploitation occur. Written procedures for investigations include Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause and providing complete and thorough documentation of the investigation.