PRINTED: 12/11/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495432	B. WING			C 11/29/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 POWHATAN STREET FALLS CHURCH, VA 22043	'	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	00		
F 658 SS=D	standard survey was 11/29/23. Correction compliance with 42 Correm Care requirement investigated during the (VA00059997-substated) The census in this 16/88 at the time of the sconsisted of 3 current closed record review. Services Provided McCFR(s): 483.21(b)(3) §483.21(b)(3) Comproved The services provided as outlined by the compustion of the services provided as outlined by the compustion. The services provided as outlined by the compustion of the services provided as outlined by the compustion of the services provided as outlined by the compustion. The facility staff failed standards of practice the survey sample; Reprovided an acceptable already identified the is cited at past non-confided. The facility staff failed physician's order to provide the provided the provided the provided the survey sample the survey sample of the survey s	FR Part 483 Federal Long ants. One complaint was be survey intiated with deficiency). O certified bed facility was survey. The survey sample at resident reviews and 1 are Professional Standards (i) ethersive Care Plans and or arranged by the facility, in more than the end of quality. The survey sample at resident standards of quality. The survey sample at residents in the survey survey standards of quality. The survey survey sample at residents in the survey surve	F 65	Past noncompliance: no plan o correction required.	of	
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	F	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: NH2656

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	ELE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		495432	B. WING			C 11/29/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 POWHATAN STREET FALLS CHURCH, VA 22043	<u> </u>	11123/2023
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 658	10/2/23 and dischardiagnosis of but no current pathological with staples to the discharge of the clin hospital discharge (from the hospital transtructions include surgery 9/21/23 Of fixation)Please of possible to schedul (name of orthopedi be seen approximal discharge from the A review of the phydated 10/3/23 for "ORTHOPEDIC FO scheduled for paties staple removal." A nurse's note date Observed on admiship area with 24 staple removal." A wound care nurse 10/5/23 documented woundNeeds sur as possible), due to Notified facility via a documented, "right	dmitted to the facility on rged on 10/20/23 and had the t limited to osteoporosis with all fracture status post surgery right hip. ical record revealed the instructions dated 10/2/23 to the facility). These and, "Date of most recent PRIF (Open reduction internal contact the office as soon as the a follow-up appointment with a surgeon). You will need to notely 2 weeks after your hospital" Instructions dated 10/2/23 to the facility). These and the office as soon as the a follow-up appointment with a surgeon and the contact the office as soon as the a follow-up appointment with the surgeon and the contact the office as soon as the after your hospital" Instructions dated 10/2/23 to the facility and the contact the office as soon as the after your hospital" Instructions dated 10/2/23 to the facility and the facility of the fac	F 65	58		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 POWHATAN STREET FALLS CHURCH, VA 22043	I	1112312023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	wound. Recommend asapNotified facing asapNotified facing asapNotified facing asapNotified facing asapNotified facing asapNotified facing as a surprise as a surp	ed, "The patient has a surgical of f/u with surgeon lity via post rounds report." If 10/13/23 documented, case worker/(name) for lout when is (Resident #1's) ment but no answer anager, POA (Power of appointment- called her son/ (name of geriatric case e of this matter). Left number)/(geriatric case ack regarding surgeon f/u unit manager aware of this illed to (agency) case ctitioner note dated 10/16/23 t hip fracture s/p ORIF/ortho o" practitioner note dated ad, "The patient has a surgical	F 6	58		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495432	B. WING			C 1/29/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2100 POWHATAN STREET FALLS CHURCH, VA 22043	•	1/23/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 658	that the care manage facility on when the stated that the care practitioner regarding that the facility called message to return of appointment. She so of her ever returning was right after the reasked if she followed appointment, she since up a second time where the care manager in facility could remove she said yes but the order to do so, becand of an x-ray first. She manager said "ok I appointment" and lead to a ware if anyone she did not recall if about the staples be residents for wound stated that the facility from the surgeon all stated that she saw both times she said appointment. She said appointment when she said appointment. She said appointment when she said appointment when she said appointment when she said appointment. She said appointment when she she said appointment when she	the appointment. She stated ger never got back with the appointment would be. She manager spoke to the nurse ag the staples. She stated at the care manager and left a call regarding the orthopedic stated that she was not aware go the call. She stated that this esident was admitted. When ad up any further regarding the stated that she "did not follow thich I should have done." I PM an interview was with a PM an interview was with a PM and interview was with the community asked if the enter the staples. She stated that the surgeon needed to send an ause sometimes they want to the stated that the care	F	658		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2100 POWHATAN STREET FALLS CHURCH, VA 22043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 658	days post surgery. Sexcessive that the reapproximately one mon 9/21/23 and was 10/20/23. She state follow up and staple facility staff multiple know why it was not outside individual (faetc.) had stated they follow up appointment through, she would exthrough with ensuring and the resident was The facility policy, "V" (6. Follow through wappropriate contact of "pharmacy")." On 11/29/23 at 3:30 Administrator, was made as followed as fo	staples are removed after 14 She stated that it was a bit esident had staples for nonth, given that surgery was discharged to home on d that the need for orthopedic removal was relayed to the times and that she did not done. She stated that if an imily member, case manager, were going to make the nt and then did not follow expect the facility to follow g the appointment was made s seen. Verbal Orders" documented, ith orders by making or notification (e.g, "lab" or PM, ASM #1 the nade aware of the findings. was provided and ws:	F 68	58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 658	trial, and failure to a presence of wound. The quality assurar explored by the fact What may have led inadequacies in the above-stated patient trial, and notification patient's pressure in does the facility has manage surgical woutification of patientication of p	ient's foley catheter for voiding notify the family of the	F 65	8	
	It is against the aborduestions that the following action plather 5-Steps Action 1. (Resident #1) won 10/20/23. Faciliappointment with the was unsuccessfuldiscontinue (Reside of her discharge or order for a voiding urologist and discontinue) (Reside (suspected deep tis from the hospital - I that included all activere discussed with during her CP (care				

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F 658	and again on 10/12/2 2. All residents are of Nursing/Unit Mansurgical/pressure injurestee the with the surgeon has removed as ordered pressure injuries conwith potential for voi accordingly. Any inanoted will be correct appropriate. Facility post-surgical wound in the management. 3. The DON/Unit May will complete the following of the following of acquired pressure in iii. Foley catheter an iv. Completing docured. 4. The DON/Ums/al 10% of all current paperssure ulcers, and weeks and then mor post-surgical protoconurses, foley catheter request/order complementation of family Any noted deficient immediately as approutcome will also be	uries to her heels on 10/5/23 23. at risk. DON/UMs (Director agers) will review all current ury wounds and foley nat those requiring follow-up is been completed, staples in family notifications for impleted, and foley catheter ding trial undertaken adequacies/deficient practices are discordingly and as in will also develop a protocol to guide the nurses of all surgical wounds. angers/Appropriate Designee owing education with the individual management protocol and address. In different discording trial management. In mented family notification. Topropriate designee will audit attents with surgical wounds, if foley catheters weekly x4 in the oli is being followed by the er with voiding trial.	F 65		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 658	Continued From page	e 7	F 65	8		
F 658	further review/guidand determines that it is in 5. Date of Compliant (End of POC) The POC documented developed for Post-S Protocol. This policy The admission and magnitude patients is an integral provided by all (facility the facility to adequate patients, particularly the below protocol in add procedures of the commatter will be followed. 1. All post-surgical patients will immediately have scheduled with their sof their admission. 2. All post-surgical patients admission. 2. All post-surgical patients admission. 3. All surgical wound even when no treatmand surgeon at the time of the surgeon at the surgeon at the surgeon at the s	ce until the meeting o longer needed. ce: 11/27/23. d that a policy was urgical Wound Management documented, in full: anagement of post-surgical part of the skilled services y company name). To help ely manage all post-surgical heir surgical wounds, the ition to the policies and mpany related to the subject d by the staff accordingly: attients admitted at the facility a follow-up appointment surgeon within 24-72 hours attients' incision sites will be on for staples and/or sutures continuation pathway in facility attending	F 65	8		
	4. Where directed by physician/practitioner surgeon to remove st should ensure to have	the attending facility for an order from the patient aple/suture, the nurse e such an order from the urs of receiving such an ttending				

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F 658	staples/sutures from incision site must be the patient admission 6. Responsible party be updated on the propatient's post-surgica 7. All surgical sites r discharging nurse to time of discharge and outcome in the patient accordingly. 8. Collaborate close	nation to remove surgical a post-surgical patient's made within 24-72 hours of to the facility. (RP), where applicable, will ogress of healing of the al incision sites. must be evaluated by the determine their status at d document the evaluation	F 6	558		
F 684 SS=D	on 11/15/23. The facility's plan of evidence was review the issue, audits of a of staff, policy develor of the implemented properties of the implemented pr	e no identified concerns with iewed. This deficiency is apliance.	F6	84		

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F 684	care plan, and the real This REQUIREMEN by: Based on staff internand clinical record real the facility staff failed of follow up care for survey sample; Resian acceptable plan of identified the concertis cited at past non-ord. The findings include The facility staff failed aftercare with the ord physician's order. The follow up the need to follow up the follow up was not resident was dischart with 24 staples still in approximately one mas 9/21/23. The facility policy, "Solution or facility and to and from such appoint of the facility policy, "Fordered Services" donursing personnel with physician ordered services and controlled the facility policy, "Fordered Services" donursing personnel with physician ordered services and clinical services and the facility policy, "Fordered Services" donursing personnel with physician ordered services and clinical services and the facility policy, "Fordered Services" donursing personnel with physician ordered services and clinical services	thensive person-centered esidents' choices. T is not met as evidenced eview, facility document review eview, it was determined that it to arrange for the provision one of four residents in the dent #1. The facility provided of correction, having already in on 10/27/23, therefore, this compliance. In d to arrange follow up thopedic surgeon per the he resident was admitted on les in a right hip surgical ders and notes documented to with the orthopedic surgeon. Ever obtained and the reged to home on 10/20/23 entact. This was nonth after the surgery, which repointments with a qualified diarranging for transportation pointments." Provision of Physician ocumented, "2. Qualified ill submit timely requests for ervices (laboratory, radiology, appropriate entity5. In	F 68	Past noncompliance: no plan of correction required.	F	

NAME OF PROVIDER OR SUPPLIER VIERRA FALLS CHURCH STREET ADDRESS, CITY, STATE, ZIP CODE 2100 POWHATAN STREET FALLS CHURCH, VA 22043 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER VIERRA FALLS CHURCH (X4) ID PREFIX TAGS (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 10 consultations are not available to be performed on-site OR the Physician has requested that services be performed at an off-site facility, this facility will work with the resident and their family to secure appropriate transportation arrangements for such appointments." Resident #1 was admitted to the facility on 10/2/23 and discharged on 10/20/23 and had the diagnosis of but not limited to osteoporosis with current pathological fracture status post surgery			495432	B. WING			C 11/29/2023
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 10 consultations are not available to be performed on-site OR the Physician has requested that services be performed at an off-site facility, this facility will work with the resident and their family to secure appropriate transportation arrangements for such appointments." Resident #1 was admitted to the facility on 10/2/23 and discharged on 10/20/23 and had the diagnosis of but not limited to osteoporosis with current pathological fracture status post surgery			1		2100 POWHATAN STREET	,	11/23/2020
consultations are not available to be performed on-site OR the Physician has requested that services be performed at an off-site facility, this facility will work with the resident and their family to secure appropriate transportation arrangements for such appointments." Resident #1 was admitted to the facility on 10/2/23 and discharged on 10/20/23 and had the diagnosis of but not limited to osteoporosis with current pathological fracture status post surgery	PRÉFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SECTION SECTIO	HOULD BE	(X5) COMPLETION DATE
A review of the clinical record revealed the hospital discharge instructions dated 10/2/23 (from the hospital to the facility). These instructions included, "Date of most recent surgery 9/21/23ORIF (Open reduction internal fixation)Please contact the office as soon as possible to schedule a follow-up appointment with (name of orthopedic surgeon). You will need to be seen approximately 2 weeks after your discharge from the hospital" A review of the physician's orders revealed one dated 10/3/23 for "COMMUNICATION ORDER: ORTHOPEDIC FOLLOW-UP needs to be scheduled for patient postop surgical visit and staple removal." A nurse's note dated 10/3/23 documented, "Observed on admission 4 surgical sites to right hip area with 24 staples all togetherNP (Nurse Practitioner) notified orders received." A wound care nurse practitioner note dated 10/5/23 documented, "The patient has a surgical woundNeeds surgical follow up ASAP (as soon	F 684	consultations are non-site OR the Physervices be perform facility will work with to secure appropria arrangements for since the secure appropriate the secure of the clinic hospital discharge of the clinic hospital discharge of the surgery 9/21/23 Of fixation)Please of the physical discharge from the consible to schedul (name of orthopedic be seen approximal discharge from the considerable of the physical discharge f	ot available to be performed sician has requested that ned at an off-site facility, this in the resident and their family atte transportation such appointments." Idmitted to the facility on reged on 10/20/23 and had the thimited to osteoporosis with a fracture status post surgery right hip. Ideal record revealed the instructions dated 10/2/23 to the facility). These does not recent attention of the facility of the facility of the facility of the facility. These does not not the facility of the facility	F 68	34		

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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 POWHATAN STREET FALLS CHURCH, VA 22043		1172072020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	documented, "right he ORIF/ortho after care	ctitioner note dated 10/5/23 aip fracture s/p (status post) ef/u (follow up) ortho." practitioner note dated ad, "The patient has a surgical af f/u with surgeon ity via post rounds report." I 10/13/23 documented, case worker/(name) for out when is (Resident #1's) ment but no answer anager, POA (Power of appointment- called her son/ (name of geriatric case e of this matter). Left number)/(geriatric case ack regarding surgeon f/u unit manager aware of this illed to (agency) case ctitioner note dated 10/16/23 at hip fracture s/p ORIF/ortho" practitioner note dated ad, "The patient has a surgical af f/u with surgeon ity via post rounds report." scharged on 10/20/23 to as still intact. No further noted regarding the status of thopedic surgeon and staple	F 6	84		

, ,		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		495432	B. WING_			C		
NAME OF PROVIDER OR SUPPLIER VIERRA FALLS CHURCH			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 POWHATAN STREET FALLS CHURCH, VA 22043		•	11/29/2023		
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F 684	manager. She stated the community came that the resident need doctor. She stated the she would schedule that the care manage facility on when the astated that the care in practitioner regarding that the facility called message to return catappointment. She stated if she followed appointment, she	PM an interview was 1 (Registered Nurse) the unit d that the care manager from to the facility and was told ded to see the orthopedic nat the care manager said he appointment. She stated or never got back with the ppointment would be. She manager spoke to the nurse in the staples. She stated the care manager and left a all regarding the orthopedic nated that she was not aware the call. She stated that this sident was admitted. When up any further regarding the ted that she "did not follow the I should have done." PM an interview was #2 (Licensed Practical are nurse. She stated that the community asked if the the staples. She stated that surgeon needed to send an use sometimes they want to e stated that the care	F 6	,				
	appointment" and left not aware if anyone f she did not recall if sl about the staples bed residents for wound of stated that the facility from the surgeon about	t. She stated that she was collowed up. She stated that the followed up with anyone cause they only see care once a week. She had not received anything out removing them. She the care manager twice and						

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F 684	manager both times She stated "We nev On 11/29/23 at 9:00 conducted with ASM Member) the Nurse typically sutures and days post surgery. excessive that the reapproximately one non 9/21/23 and was 10/20/23. She state follow up and staple facility staff multiple know why it was not outside individual (faetc.) had stated they follow up appointment through, she would a through with ensurin and the resident was On 11/29/23 at 3:30 Administrator, was read A plan of correction documented as follow Initiated on 10/27/23 5-Steps Action Plan Surgical Wound/Voice Management The Situation: On 10/27/23, the Adallegation of neglect of (Resident #1), a put that was at the facilir	tated that she told the care the facility needed the order. er received the order." AM an interview was I #4 (Administrative Staff Practitioner. She stated that I staples are removed after 14 She stated that it was a bit esident had staples for month, given that surgery was discharged to home on d that the need for orthopedic removal was relayed to the times and that she did not done. She stated that if an emily member, case manager, were going to make the nt and then did not follow expect the facility to follow g the appointment was made as seen. PM, ASM #1 the nade aware of the findings. was provided and ws:	F6	84				

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		495432	B. WING _			C 11/29/2023	
NAME OF PROVIDER OR SUPPLIER VIERRA FALLS CHURCH				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 POWHATAN STREET FALLS CHURCH, VA 22043			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pag	ge 14	F 6	84			
	removal of patient's discontinue the patie trial, and failure to no presence of wounds	•					
	explored by the facil What may have led inadequacies in the above-stated patientrial, and notification patient's pressure in does the facility havmanage surgical wo notification of patien facility? What additibeen put in place to	ce questions, therefore, ity included the following: to the possible alleged management of the t's surgical staples, voiding of the family about the juries? What framework e in place to holistically unds, voiding trial, and family ts' pressure injuries at the onal resources could have mitigate the incidence of the s in care provision at the					
	following action plan The 5-Steps Action 1 1. (Resident #1) wa on 10/20/23. Facility appointment with the was unsuccessful - I discontinue (Reside of her discharge on order for a voiding tr urologist and discon 10/20/23 for a trial - discharge. (Resider (suspected deep tiss from the hospital - h that included all acti	cility will implement the below: Plan: s discharged from the facility attempted to coordinate an e surgeon on 10/13/23 but					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495432	B. WING _			l	29/ 2023
NAME OF PROVIDER OR SUPPLIER VIERRA FALLS CHURCH				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 POWHATAN STREET FALLS CHURCH, VA 22043	Ē		
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F 684	#1) son was also noting bilateral pressure injurand again on 10/12/2 2. All residents are a of Nursing/Unit Mana surgical/pressure injurcatheter to ensure the with the surgeon has removed as ordered, pressure injuries common with potential for void accordingly. Any inarenoted will be corrected appropriate. Facility post-surgical wound prost-surgical wound prost-surgical wound in the management of 3. The DON/Unit Markill complete the following in the management of ad acquired pressure injurii. Foley catheter and iv. Completing docum. 4. The DON/Ums/ap 10% of all current pat pressure ulcers, and	plan) conference. (Resident fied about the admitted-with ries to her heels on 10/5/23 a. It risk. DON/UMs (Director gers) will review all current ry wounds and foley at those requiring follow-up been completed, staples family notifications for pleted, and foley catheter ing trial undertaken dequacies/deficient practices d accordingly and as will also develop a protocol to guide the nurses f all surgical wounds. Ingers/Appropriate Designee wing education with the d management protocol and dures. Initted with and inhouse uries. I voiding trial management. I voiding trial management. I propriate designee will audit ients with surgical wounds, foley catheters weekly x4	F 6	,			
	post-surgical protoco nurses, foley catheter request/order comple notification of family a Any noted deficient p						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED			
		495432	B. WING			C 1/29/2023		
NAME OF PROVIDER OR SUPPLIER VIERRA FALLS CHURCH				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 POWHATAN STREET FALLS CHURCH, VA 22043		·		
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F 684	Continued From pag		F 68	34				
	Risk Meeting and/or further review/guidal determines that it is 5. Date of Compliar (End of POC) The POC document	nce: 11/27/23.						
	Protocol. This policy	y documented, in full:						
	patients is an integral provided by all (facility the facility to adequate patients, particularly below protocol in ad procedures of the co	management of post-surgical al part of the skilled services ity company name). To help ately manage all post-surgical their surgical wounds, the dition to the policies and ompany related to the subject ed by the staff accordingly:						
	will immediately hav scheduled with their of their admission. 2. All post-surgical passessed on admission determine their diconsultation with the physician/practitione surgeons. 3. All surgical woun even when no treatmer surgeon at the time or post admission for the directed by physician/practitione surgeon to remove services.							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495432	B. WING		C 11/29/2023	
NAME OF PROVIDER OR SUPPLIER VIERRA FALLS CHURCH			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 POWHATAN STREET FALLS CHURCH, VA 22043		·	
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F 684	instruction from the a physician/practitione 5. Definitive determ staples/sutures from incision site must be the patient admissio 6. Responsible part be updated on the p patient's post-surgic 7. All surgical sites discharging nurse to time of discharge an outcome in the patie accordingly. 8. Collaborate close in coordinating post-management. (End of policy) This policy was sign on 11/15/23. The facility's plan of evidence was review the issue, audits of a of staff, policy develop the implemented paties.	attending er. ination to remove surgical a post-surgical patient's made within 24-72 hours of n to the facility. y (RP), where applicable, will rogress of healing of the al incision sites. must be evaluated by the determine their status at d document the evaluation nt's clinical record ely with the wound specialist surgical patients' incision site ed by the Director of Nursing correction and credible wed, including identification of all other residents, education opment, and ongoing audits olan of correction, on re no identified concerns with viewed. This deficiency is	F 684			