STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495319	A. Building B. Wing	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Boulevard Post Acute	9229 Arlington Blvd Fairfax, VA 22031

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview and facility documentation review, the facility staff failed to implement their abuse policy for 2 employees (CNA D and LPN D) out of a survey sample of 5 employees. Specifically, CNA D and LPN D did not receive annual abuse training in 2021. The findings included: On 03/09/2022, the facility staff provided a copy of training transcripts for Certified Nursing Assistant D (CNA D) and Licensed Practical Nurse D (LPN D). According to the training transcripts for CNA D (date of hire 11/25/2009), the most recent abuse training occurred on 03/06/2020. According to the training transcripts for LPN D (date of hire 10/29/2018), the most recent abuse training occurred on 06/13/2019. On 03/10/2022 at approximately 11:45 A.M., the administrator and Director of Nursing were notified of findings. The Director of Nursing stated they would look into it. According to their facility policy entitled, Abuse in Section 3 entitled, Training it was documented, Each new staff member shall receive an orientation and training reporting abuse and neglect, . These shall be reviewed annually. On 03/10/2022 at approximately 12:50 P.M., he Director of Nursing acknowledged the lack of annual abuse training for CNA D and LPN D. The Director of Nursing then stated, We'll be working on that. On 03/10/2022 at approximately 2:00 P.M., the administrator and Director of Nursing stated they had no further documentation or information to submit.

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and facility documentation the facility staff failed to review and revise the care plan for 1 Resident #58 in a survey sample of 32 Residents. The findings included: For Resident #58 the facility staff failed to review and revise the care plan to include measurable objectives and timeframes for interventions. On 3/9/22 a review of the clinical record revealed that Resident #58 had 2 falls since his admission on [DATE]. The first fall occurred on 2/22/22 at 4:45 AM, the progress note read: 2/22/22 at 5:20 AM - Writer was sitting at nurse's station at 0445. Heard a small voice yelling out, Help Help. As I got up from behind nurses station and looked up both hallways, I observed resident lying-in the floor in prone position in front of [room number redacted] doorway. He was alert and verbal. Aspen collar intact. Resident assessed and was able to assist with repositioning himself into supine position. Neck and upper extremities supported at all times. Resident observed lifting both legs high in the air and bending his knees w/o being instructed to. Tolerated AROM to all extremities w/o c/o pain or discomfort. Neuro checks done and all were WNL. PEARL, bilateral hand grasps equal in strength. v/s 96.9 75 20 148/72 O2 sats 96%. Resident assisted into a sitting position w/o complaints. Then into standing position. Transferred into a wheelchair and was assisted back into bed. Resident observed with 4 skin tears in total on complete head to toe assessment. Rt elbow ST measuring 3.2x3cm. A review of the care plan revealed that the facility initiated the following interventions after the first fall. Approach Start Date: 02/22/2022 -Round on resident Q1H for safety -Certified Nurse Aide (CNA), Nursing. On 3/10/22 at 11:00 AM an interview was conducted with the DON who was asked when the hourly checks started and ended. She stated she could not find the records of the hourly checks being done. She stated in her opinion it was because it was not put in as Display on POC so it was not in the system for the CNA's and or Nurses to check off. She was asked based on the care plan could you tell when the hourly checks were to end. She stated she could not tell from the care plan. She stated In my opinion the care plan should have had the hourly checks quantified with a start and stop date. On 3/10/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation, and during the course of an investigation the facility staff failed to ensure Residents are free from accidents and hazards for 2 Residents (#21 & #58) in a survey sample of 32 Residents resulting in harm for Resident #21. The findings included: 1. For Resident #21 the facility staff failed to transfer the Resident using the required number of staff as indicated on the MDS and the care plan, subsequently she sustained a skin tear requiring sutures, which became infected; this is harm. On 3/9/22 a review of the clinical record revealed that Resident #21 sustained an injury to her right leg while transferring from wheel chair to bed on 2/7/22. The Resident was transferred by one staff member. The most recent MDS with an ARD of 1/24/22 revealed that Section G coded the Resident as #3 -Extensive Assistance of #3 -2 or more persons Physical Assistance. Resident #21 was coded with moderate cognitive impairment. The care plan read as follows: Approach start date 1/17/22 - I need extensive assistance with transfers. I need 2 person staff support with transfers. Resident #21 was taken to the emergency room and required sutures to close the 7 cm x 6 cm x 0.1 cm skin tear. The Resident was sent back to the facility with instructions for wound care. Excerpts from the hospital ER Record are as follows: 2/7/22 at 11:01 PM - Well-appearing [age and gender redacted] coming to us from facility with skin tear/ laceration to the right lateral mid shin. Is quite extensive tear and goes fairly deep. There is some oozing from the wound as well. The muscle been a skin avulsion [sic] as well as the wound does not entirely come together. The wound is been repaired by the physician assistant. Please see her note for the procedure. The skin is quite think in this area and I do feel that it is possible that the wound will not heal well. I think there is a chance that there could be dehiscence or even wound degradation and so therefore of counseled the family that she needs very close follow-up with the wound care team. They state they have one at the facility where she is staying. Have also counseled them follow-up with [Hospital name redacted] in the next couple of days to make sure that this wound is healing well. Family is comfortable with plan for discharge home knows to return to the ER sooner if there are any new or worsening symptoms. Will give prescription for antibiotics as well.The Resident returned to the facility. However on 2/17/22, the wound physician noted signs of infection and wrote new orders. Excerpts from the RN note written on 2/17/22 at 2:08 PM read as follows: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Right lateral shin 9 cm x 7 cm x 3 cm with light purulent drainage and 100% necrosis. New order to cleanse area with Dakin's solution, pat dry, pack with Dakin's solution-soaked gauze and cover with and ABD and wrap with Kerlix and ace wrap daily. New order for Rocefin [sic] IV ABT daily. New orders transcribed and emergency contact acknowledged via telephone. Excerpts from the Nurse Practitioner note entered on 2/17/22 at 3:20 PM read: Patient seen and examined, her right shin wound was observed with notable signs of infection, suture line skin is partially loosened & necrotic with underlying hematoma. She was seen by wound team and hematoma was evacuated, sutures removed. exacerbated with wound care. On 3/9/21 at approximately 3:00 PM an interview was conducted with the DON who stated that the injury was sustained with a staffing agency CNA who was providing care and transferred her without assistance of a second person. The DON stated the resident has fragile skin and has a history of injuring her legs during transfer. On 3/10/22 at approximately 11:15 AM an interview was conducted with LPN B who was asked where the CNAs get information on how each Resident needs to be transferred. LPN B stated that the CNA's look in the care plan. On the afternoon of 3/9/22 an interview was conducted with CNA C who stated that on 2/7/22 he asked the Resident if she could help with the transfer and she stated that she could. He stated that he used extreme care however when he transferred her to the bed he noticed she had a skin tear to her right leg. He stated he immediately notified the LPN. On the afternoon of 3/9/22 an interview was conducted with CNA D who stated that she found the skin tear on 3/22/22 when she was undressing the resident for bed. She stated the wound had dried blood on it when she discovered it. She denied having knowledge of how the wound occurred. On 3/10/21 at approximately 11:00 AM an interview was conducted with CNA B who was asked how a CNA knows each Resident needs to be transferred. CNA B stated that she will ask the Resident or ask another CNA or nurse. On 3/10/22 at approximately 10:45 AM an interview with Resident #21 was conducted and she stated As far as I can remember I hit my leg on the wheel chair On 3/10/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #58 the facility staff failed to provide adequate supervision (hourly checks as stated in care plan) to ensure Resident safety after initial fall on 2/22/22. On 3/9/22 a review of the clinical record revealed that Resident #58 had 2 falls since his admission on [DATE]. The first fall occurred on 2/22/22 at 4:45 AM, the progress note read: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2/22/22 at 5:20 AM - Writer was sitting at nurse's station at 0445. Heard a small voice yelling out, Help Help. As I got up from behind nurses station and looked up both hallways, I observed resident lying-in the floor in prone position in front of [Room number redacted] doorway. He was alert and verbal. Aspen collar intact. Resident assessed and was able to assist with repositioning himself into supine position. Neck and upper extremities supported at all times. Resident observed lifting both legs high in the air and bending his knees w/o being instructed to. Tolerated AROM to all extremities w/o c/o pain or discomfort. Neuro checks done and all were WNL. PEARL, bilateral hand grasps equal in strength. v/s 96.9 75 20 148/72 O2 sats 96%. Resident assisted into a sitting position w/o complaints. Then into standing position. Transferred into a wheelchair and was assisted back into bed. Resident observed with 4 skin tears in total on complete head to toe assessment. Rt elbow ST measuring 3.2x3cm. A review of the care plan revealed that the facility initiated the following interventions after the first fall. Approach Start Date: 02/22/2022 -Round on resident Q1H for safety -Certified Nurse Aide (CNA), Nursing. The second fall the Resident sustained was one day later on 2/23/22 at approximately 4:34 AM the progress note read 2/23/22 at 4:34 AM - Writer was sitting at nurses station and heard someone yelling out Help Help. Writer immediately got up from nurses station and immediately went into [Room number redacted], turned the light on and observed resident kneeling at the side of his roommates' bed. Aspen collar on and resident was observed still connected to his IV. Neuro check done and all WNL. Resident asked by writer, Why are you on the floor, resident replied, I don't know, I'm crazy. Skin abrasion observed on RT mid back. Resident assisted back into bed by three staff. Bed kept in lowest position at all times. v/s 96.7 78 20132/76 O2 sats 97% [MD name redacted] was made aware and no new orders received. Call was placed to resident's son [name redacted] and message was left on voicemail to call facility when available. On 3/10/22 at 11:00 AM an interview was conducted with the DON who stated she could not find the records of the hourly checks being done. She stated in her opinion it was because it was not put in as Display on POC so it was not in the system for the CNA's and or Nurses to check off. When asked if this meant the checks were not being done she stated they were not. On 3/10/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free from unnecessary psychotropic medications for 2 Residents (#'s 53 & 58) in a survey sample of 32 Residents. The findings included: 1. For Resident # 53 the facility failed to ensure the Resident's PRN Xanax order did exceed 14 days without Resident being seen by physician and a new prescription being written. On 3/19/22 a review of the clinical record revealed that among Resident # 53's orders was an order for Xanax written by the facility medical doctor (MD) that read: Received date: 2/8/22 Start date 2/9/22 End Date: Open Ended [no stop date] Drug Name: Alprazolam 0.5 mg [Xanax] Give 1 tablet nightly as needed. The clinical record also included a consult from the Psychiatric MD to D/C Seroquel, keep Abilify and Maintain Wellbutrin as well as the PRN Xanax 0.5 mg order. On 3/9/22 an interview was conducted with the DON who was asked if she was aware of regulations regarding the administration of as needed (PRN) psychotropics. She stated she was aware that they should be only prescribed for 14 days and then had to be re-evaluated by the physician. When asked about the Xanax order for Resident # 53 she stated she would have to look to see if pharmacy did a medication review and had it changed to scheduled. Upon review of the pharmacy consults she did not find any pharmacy recommendations for changes to the original order written on 2/8/22. On 3/10/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #58 the facility staff failed to ensure the Resident's PRN Ativan order did not exceed 14 days without Resident being seen by physician and a new prescription being written. A review of the clinical record for Resident #58 revealed a PRN order for Lorazepam (Ativan) that read: Lorazepam - Tablet; 0.5 mg; am: 1 Tab; oral Every 6 Hours - PRN PRN 1, PRN 2, PRN3, PRN 4 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Start Date 2/16/22 End Date: Open ended [no stop date] The clinical record also included a consult from the Psychiatrist dated 2/23/22 under Psych Meds the following were listed: Trazadone 25 mg at hs [hour of sleep] Neurontin 200 mg every 8 hrs. Melatonin 10 mg every hs A review showed there was no mention of Lorazepam in the Psychiatry Consult. On 3/9/22 an interview was conducted with the DON who was asked if she was aware of regulations regarding the administration of PRN psychotropics. She stated she was aware that they should be only prescribed for 14 days and then had to be re-evaluated by the physician. When asked about the Lorazepam order for Resident #58 she stated she would check into the order. The DON presented the Psychiatric Consult dated 2/23/22. She also stated she did not find any pharmacy recommendations for the original order written on 2/16/22. On 3/10/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility documentation review, the facility staff failed to provide and/or document pneumonia vaccination status for 2 Residents (Resident #43 and #59) in a survey sample of 5 Residents reviewed for immunizations. The findings included: 1. For Resident #43, who had consented to receive the pneumonia vaccine, the facility staff failed to administer the vaccine prior to surveyor intervention. Resident #43 was admitted to the facility on [DATE]. On 11/9/21, the facility staff inquired about vaccination status of Resident #43 and noted the following: 1. When did the Resident last receive a flu or pneumococcal vaccination? Unknown date was recorded for flu and pneumonia both. 2. Signed Consent has been obtained for this Resident to receive the following vaccinations, was noted as yes. Review of the electronic health record revealed no indication that the vaccines were administered. On 12/26/2021, Resident #43 was discharged to the hospital and returned on 1/5/2022. On 1/5/22, the facility staff recorded the following information regarding vaccination status. 1. When did the Resident last receive a flu or pneumococcal vaccination? No Known Dates or Proof for Flu, Pneumococcal, or Shingles Vaccinations. 2. Signed Consent has been obtained for this Resident to receive the following vaccinations: Pneumococcal Vaccine - Already received, Influenza Vaccine - Already received. Review of the clinical record revealed no indication that the flu or pneumococcal vaccinations being administered. On 1/27/22, Resident #43 was discharged to the hospital. On 2/3/22, Resident #43 was readmitted and vaccination status was assessed as: 1. When did the Resident last receive a flu or pneumococcal vaccination? Influenza- Already received. Pneumococcal - No 2. Signed Consent has been obtained for this Resident to receive the following vaccinations: Pneumococcal Vaccine - Yes, Influenza Vaccine - No. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for February revealed an order, Pneumococcal vaccination- Q5 [every] years. Offer both PCV-13 and PPSV23 vaccinations (document both separately if declined). If accepted, receive M.D. order and schedule PCV-13 immunization first, followed by PPSV23 immunization one year later. The administration of this immunization was recorded as Not Administered: Resident unavailable. There were no nursing notes to indicate why Resident #43 was not administered the vaccine or why unavailable was noted. On 3/8/22, the DON (Director of Nursing) was asked to provide any evidence she had regarding Resident #43's immunization. On 3/9/22, the DON stated that Resident #43 would receive the pneumonia vaccine that day. On 3/10/22, review of the nursing notes for Resident #43 revealed an entry that read, Resident given Prevnar-13 pneumococcal vaccine into left deltoid. Lot number-EJ4560. Expiration date- 07/01/2023. Resident tolerated procedure well. Will continue to monitor. 2. For Resident #59, the facility staff failed to confirm and document the pneumonia vaccination status in the clinical record. Resident #59 was admitted to the facility on [DATE]. Review of the clinical record for Resident #59 revealed that on 2/17/22, Resident #59 was assessed by facility staff for his immunization status. This information read, When did the Resident last receive a flu or pneumococcal vaccination? Pneumococcal - Needs verification. On 3/9/22, the DON (Director of Nursing) was asked about Resident #59's pneumococcal vaccination status. On 3/10/22, the DON provided the survey team with a document that indicated Resident #59 received the pneumonia vaccine outside of care setting [meaning outside of the facility], date unknown, vaccine type unknown. The DON also stated this information has now been included in the clinical record of Resident #59. On 3/10/22, during an interview with the DON, she confirmed that immunization status should be documented in the clinical records of Residents and Resident #59's status was not previously documented appropriately. A review of the facility policy titled, Pneumococcal Vaccine, was conducted. This policy read, 1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. 2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission .4. Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician approved pneumococcal vaccination protocol. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/9/22, during an end of day meeting, the facility Administrator and DON were made aware of the findings. No further information was provided.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to document in the clinical record a Resident's COVID-19 status for two Residents (Resident #59 and #30) in a survey sample of 5 Residents reviewed for immunizations. The findings included: 1. For Resident #59, the facility staff failed to document in the clinical record, the Resident's COVID vaccination status. Resident #59 was admitted to the facility on [DATE]. On 3/8/22, a review of the entire clinical chart revealed no documentation regarding Resident #59's immunization status with regards to COVID-19. There was no documentation to support that the Resident was educated on the COVID-19 immunization and offered to be vaccinated. On 3/8/22, the DON (Director of Nursing) was notified that no COVID vaccine information for Resident #59 was noted. On 3/9/22, the DON stated, The family gave us the dates but the admissions didn't have a card to upload. The DON was asked if the vaccination status should be documented in the clinical record regardless if the vaccine card is available or not, and the DON stated, Yes. On 3/10/22 at 8:32 AM, an interview was conducted with LPN D. LPN D stated, We document in the progress notes when asked where immunization information is found. LPN D stated, Knowing immunization status is very important so we know they have gotten the vaccination and we can check them. LPN D was asked if she needs to know a Resident's COVID immunization status in the event a Resident experiences a change in condition and needs to be sent to the hospital. LPN D said, Yes, when we send them out EMS [emergency medical services] will ask for all of those documents/information, so they can take precautions. We have to protect the Resident and the people providing care. 2. For Resident #30, the facility staff failed to document in the clinical record if the Resident received all COVID vaccinations. On 3/8/22, a clinical record review was conducted. This review revealed evidence that Resident #30 had received 1-dose of a multi-dose COVID vaccine, Pfizer on 10/14/21. There was no further documentation to indicate if the Resident received the second dose, was educated and offered the second dose following admission, or if the Resident declined the second dose. On 3/8/22, the DON was made aware of the findings and stated, I know what happened, and it is in her assisted living chart. On 3/9/22, the DON stated that Resident #30's clinical chart had now been updated to reflect that she was fully vaccinated for COVID-19. (continued on next page)

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/9/22, the DON was asked if she thought the vaccination status should be noted in the clinical record and she said, It was supposed to have been. A review of the facility policy titled, COVID-19 Vaccine - Residents was conducted. This policy read, 1. The COVID-19 vaccine will be offered to residents, unless the vaccine is medically contraindicated or the resident has already been immunized .2. Residents may obtain their COVID-19 vaccines from their personal physicians or at other community locations. Documentation of previous vaccination will be provided to the facility. 3. Booster doses of the COVID-19 vaccine will be offered to all residents if eligible. New admissions and residents who are not yet eligible will be offered the booster vaccine within 30 days of the resident being admitted or becoming eligible . 4. Residents will be offered the vaccine at the time of the resident's admission to the facility (healthcare center) and will be administered when available in the facility (healthcare center). 5. Prior to the vaccination, the resident (or resident's legal representative) will be provided information and education regarding the benefits and potential side effects of the COVID-19 vaccine. Provision of such education will be documented in the resident's medical record. A copy of the vaccine fact sheet provided may be retained in the resident's file. 6. In those situations where COVID-19 vaccination requires multiple doses the resident (or resident's legal representative) will be provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine before requesting consent for administration of any additional doses 9. Documentation in the resident's medical record will include at a minimum: That the resident or resident representative was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine; and each dose administered, including additional doses or boosters, or If the resident did not receive the vaccine due to medical contraindications, religious beliefs, or refusal; and The COVID-19 vaccination status of the resident . On 3/9/22, during an end of day meeting the facility Administrator and DON were made aware of the findings. No further information was provided.