

Health Regulation & Licensing Administration

|                                                     |                                                                              |                                                                        |                                                                    |
|-----------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HFD-0214</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/16/2026</b> |
|-----------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

|                                                                            |                                                                                               |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGE WASHINGTON UNIV HOSPITAL</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>900 23RD ST NW</b><br><b>WASHINGTON, DC 20037</b> |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| H 000                    | Initial Comments<br><br>An unannounced complaint [DC~00013997 & DC~00014071] survey was conducted at George Washington University Hospital from 01/09/2026 to 01/16/2026. The facility's census was 311 on the first day and 308 on the last day of survey. The sample size was 11 patients. Deficiencies were cited related to the investigation of DC~00014071. There were no deficiencies cited related to DC~00013997.<br><br>The following deficiencies are based on observations, medical record review, hospital policy review, and staff interviews.                                                                                                                                                                 | H 000               |                                                                                                                          |                          |
| H 145                    | 2024.4 Hospitals<br><br>Each hospital shall provide the necessary care and treatment to meet the needs of patients. Care and treatment provided shall meet prevailing professional standards and scope of practice requirements. Each hospital shall establish and implement written policies and procedures that encompass care and treatment provided to patients.<br><br>This CONDITION is not met as evidenced by:<br><br>Based on the medical record and policy review staff interview, the nursing staff failed to consistently document 1.) pressure ulcer risk assessments for one (1) of eight (8) (Patient #1) and 2.) external catheter changes every shift for three (3) of eight (8) patients ( Patients #1,#2, | H 145               |                                                                                                                          |                          |

Health Regulation & Licensing Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

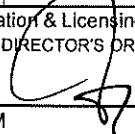
(X6) DATE

STATE FORM

6699

OXJM11

If continuation sheet 1 of 4

 **Ulises Torres, MD** **Chief Quality Officer** **3/12/26**

Health Regulation & Licensing Administration

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                          |                                                                    |
|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HFD-0214</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/16/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGE WASHINGTON UNIV HOSPITAL</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>900 23RD ST NW</b><br><b>WASHINGTON, DC 20037</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X5)<br>COMPLETE<br>DATE |                                                                    |
| H 145                                                                      | <p>Continued From page 1<br/>and #3.).</p> <p>Findings included:</p> <p>Review of the facility's policy titled "Wound Care- Pressure Ulcer Risk Assessment" revised 11/10/2025 showed "...IV. Policy: A. All patients should be assessed for pressure ulcer risk and presence of pressure ulcers/skin abnormalities on admission, upon transfer and every shift utilizing a validated risk assessment scale. In addition, the paired Registered Nurse assessment (2 Registered Nurses) known as 4 Eyes should be performed within 4 hours of admission and 4 hours of transfer to another unit. The integumentary assessment should be documented every shift. B. Documentation of the risk assessment should be made in the electronic health record.</p> <p>According to the facility's "Urinary Incontinence Product and Device Algorithm" guideline dated 12/21/2025 showed " Maintain Versette external female urinary management device at 60 mmHg continuous suction, changing qShift [every shift] and as needed for leakage/soilage."</p> <p>1.A review of the medical record showed Patient #1 was admitted with a diagnoses that included but were not limited to, Refractory Diffuse Large B-cell Lymphoma , Hypertension, Chronic Obstructive Pulmonary Disease, Asthma, and Obesity Hypoventilation Syndrome.</p> <p>The medical record lacked documentation of a pressure ulcer risk assessment on days: 12/2/2025 (nightshift), 12/6/2025 (dayshift/nightshift), 12/7/2025 (dayshift/nightshift), and 12/8/2025 (dayshift).</p> | H 145                                                                        | <p>Nursing Leadership and the Quality Director reviewed the finding regarding inconsistent documentation of Braden Scale pressure ulcer risk assessments every shift. The review confirmed that nurses did not follow established hospital procedures.</p> <p>Education on completing a Braden Scale pressure ulcer risk assessment will be assigned to all medical surgical nurses through a HealthStream e-learning module with a 100% goal for attestation of understanding.</p> <p>Unit leadership or designee will conduct 5 weekly chart audits on medical surgical patients for documentation of the Braden Scale pressure ulcer risk assessment. Any non-compliance will be remediated with RN re-education.</p> <p>Compliance results will be reported monthly to the Hospital Quality Council until ≥ 90% compliance is sustained for 3 consecutive months.</p> <p>Responsible Party: Chief Nursing Officer</p> | 3/6/26                   | 5/15/26                                                            |
|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5/15/26                  | 5/15/26                                                            |

Health Regulation & Licensing Administration

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                            |                                                                    |
|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HFD-0214</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/16/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGE WASHINGTON UNIV HOSPITAL</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>900 23RD ST NW</b><br><b>WASHINGTON, DC 20037</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                            |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X5)<br>COMPLETE<br>DATE                                   |                                                                    |
| H 145                                                                      | <p>Continued From page 2</p> <p>The surveyor conducted an interview on 1/12/2026 at approximately 10:00 AM with Employee #3, Nurse Educator. According to Employee #3, the facility uses the Braden Scale as a validated pressure ulcer risk assessment tool to determine a patient's risk for developing pressure ulcers. Employee #3 additionally stated the Braden Scale should be documented every shift by nursing staff and acknowledged the missing documentation on the dates identified above.</p> <p>2a.A review of the medical record showed Patient #1 was admitted with a diagnoses that included but were not limited to, Refractory Diffuse Large B-cell Lymphoma , Hypertension, Chronic Obstructive Pulmonary Disease, Asthma, and Obesity Hypoventilation Syndrome.</p> <p>Medical record review showed Patient # 1 used a Versette- External Urinary Collection Device on the following days: 1/4/2026, 1/7/2026, 1/8/2026, and 1/12/2026.</p> <p>Further review showed a lack of documentation indicating the external catheter was changed every shift during the identified dates above.</p> <p>2b.A review of the medical record showed Patient #2 was admitted with a diagnosis to include, but not limited to Lung Cancer, Chronic Obstructive Pulmonary Disease, Hypertension, and Diabetes.</p> <p>Medical record review showed Patient # 2 used a Versette- External Urinary Collection Device on the following days: 1/8/2026, 1/9/2026, 1/11/2026, and 1/12/2026.</p> <p>Further review showed a lack of documentation indicating the external catheter was changed</p> | H 145                                                                                         | <p>Nursing Leadership and the Quality Director reviewed the finding regarding inconsistent documentation of external catheter changes every shift. The review confirmed that nurses did not follow established hospital procedures.</p> <p>Education on documenting external catheter changes will be assigned to all medical surgical nurses through a HealthStream e-learning module with a 100% goal for attestation of understanding.</p> <p>Unit leadership or designee will conduct 5 weekly chart audits on medical surgical patients for documentation of external catheter changes every shift. Any non-compliance will be remediated with RN re-education.</p> <p>Compliance results will be reported monthly to the Hospital Quality Council until ≥ 90% compliance is sustained for 3 consecutive months.</p> <p>Responsible Party: Chief Nursing Officer</p> | <p>3/6/26</p> <p>5/15/26</p> <p>5/15/26</p> <p>5/15/26</p> |                                                                    |

Health Regulation & Licensing Administration

|       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |       |  |  |
|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|
| H 145 | <p>Continued From page 3</p> <p>every shift during the identified dates above.</p> <p>2c.A review of the medical record showed Patient #3 was admitted with a diagnosis to include, but not limited to Schizophrenia, Seizure disorder, Paraplegia, and Morbid Obesity.</p> <p>Medical record review showed Patient # 3 used a Versette- External Urinary Collection Device on the following days: 1/7/2026, and 1/8/2026.</p> <p>Further review showed a lack of documentation indicating the external catheter was changed every shift during the identified dates above.</p> <p>The surveyor conducted an interview on 1/12/2026 at approximately 10:18 AM with Employee #3. According to the employee the external should be changed once during every shift and as needed, if soiled in accordance with facility guidelines. The employee additionally acknowledged that documentation indicating the external urinary catheter was changed was missing for Patients #1, #2, and #3 on the dates identified above.</p> | H 145 |  |  |
|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|

|                                                                     |                                                                       |                                                                                 |                                                      |
|---------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>HFD-0214 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____           | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>01/16/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GEORGE WASHINGTON UNIV HOSPITAL |                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 23RD ST NW<br>WASHINGTON, DC 20037 |                                                      |