PRINTED: 03/22/2018 FORM APPROVED

State of Virginia
STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED					
VA0164		B. WING		06/22/2017						
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE						
DOCKSIDE HEALTH & REHAB CENTER 74 MIZPAH ROAD										
DOCKSID	E HEAEIII & KEHAB CE	LOCUST H	ILL, VA 23092	2						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	OULD BE COMPLETE					
F 000	0 Initial Comments		F 000							
	survey and biennial S was conducted 6/20/Corrections are requirements and the Regulations for the L Facilities. The Life S follow. Two complain the survey. The census in this 63 at the time of the survey consisted of 13 curres.	ired for compliance with 42 al Long Term Care e Virginia Rules and icensure of Nursing afety Code survey/report will ts were investigated during B certified bed facility was 59 vey. The survey sample ent Resident reviews th #13) and 3 closed record								
F 001	Non Compliance		F 001			8/5/17				
	The facility was out of compliance with the following state licensure requirements:									
	•	n compliance with the les and Regulations for the		Preparation and submission of this PC required by state and federal law. Thi POC does not constitute an admission purposes of general liability, profession malpractice or any other court procee	is n for nal					
		iew and facility w, the facility staff failed to 11 of 21 employees prior to		References were obtained and/or attempted with results documented fo employees that were found to be defice and placed in the employee file.						
	was conducted. Refe	t: f the facility's employee files erences were not available es for the licensure portion of		2. All current employee files will be reviewed to ensure documentation of references were attempted and/or obtained. Those employees found to deficient will have two references obtained.	be					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

07/07/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		VA0164	B. WING		06/22/2017		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 MIZPAH ROAD LOCUST HILL, VA 23092							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETE		
F 001	(other A). He stated, information, but I don Review of the facility's 3/3/17 revealed the form the following prior to I Generally attempt two employees for an app On 6/22/16 at approx Administrator was not 12 VAC 5-371-110 (B F-225, F-226 COV 12 VAC 5-371-250(G 12VAC 5-371-220 (C) 12 VAC 5-371-220 (A)	AM, an interview was uman Resources Director "I call and get the "t write it down." s abuse policy revised on ollowing: "The facility will do niring a new employee: o references from 2 prior	F 001	and/or attempted. Results will be documented and placed in the employ file. 3. A list of required information will be utilized for all new hires to ensure all information has been obtained includ reference checks. All new hires will have two reference checks obtained and/or attempted with documentation before hiring. All hiring managers will be educated or regulation and protocol. 4. Administrator will review all new hire for documentation of attempt and/or obtaining two reference checks prior hire date for three months. Results will be reviewed in monthly Grameeting for three months then review for on-going auditing. 5. August 5, 2017	e ing th on ires to		