State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2586	A. BUILDING _____ B. WING _____	08/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE IN NORTHERN VIRGINIA	5000 FAIRBANKS AVENUE ALEXANDRIA, VA 22311

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 8/9/17 through 8/11/17. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 121 bed facility was 43 at the time of the survey. The survey sample consisted of 5 current Resident reviews (Residents' #1 through #5) and 1 closed Resident record (Resident #6).	F 000	Please accept this *Plan of Correction* as our credible allegation of compliance. Preparation and/or execution of the *Plan of Correction* does not constitute admission, or agreement, by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The *Plan of Correction* is prepared and/or executed solely because it is required by the licensing entity.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12VAC 5-371-140 Based on staff interview, facility document review, and employee file review, the facility staff failed to follow their policy and procedure in regards to new employee hires for 1 of 25 new hires. New hire #13. The findings included: For new hire #13, the facility staff failed to verify the employee's professional license. Two surveyors reviewed 25 employee files on 08/10-11/17. Of the 25 employee files reviewed, 1 was incomplete. New hire #13 was hired at the facility on 06/20/17 as a CNA (certified nursing assistant). The employee file did not include documentation	F 001	12VAC 5-371-140 All residents have the potential to be affected by employment of unqualified caregivers. The professional license of new hire #13 has been verified and documented in his/her personnel file. License verification documents will be reviewed and initialed by the Director of Nursing or Director of Assisted Living prior to an offer of employment. This document will be reviewed by the Administrator before issuing an offer letter. New hire personnel files will be reviewed for compliance not less than quarterly and results included as part of the Quality Assurance process.	8.14.17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn Watkins | TITLE: Administrator | (X6) DATE: 9.11.17

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F 001	Continued From Page 1 to indicate the employee's professional license had been verified. The HR director stated, "I know I verified it, but I cannot find it". The administrative staff was notified of the incomplete employee files during a meeting with the survey team on 08/11/17 at approximately 10:30p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12 VAC 5-371-170 Based on observation, staff interview, and facility document review, the facility failed to designate a physician to meet at least quarterly with the QA committee. The findings include: On 8/11/17 at 9:50a.m., a quality assessment/assurance (QA) review was conducted with the director of nursing regarding the facility Quality Assessment and Assurance committee meetings. Review of the QA minutes revealed the medical director had not attended 3 of the meetings over 2 years. The January and the October 2016 meeting he did not attend. He also did not attend the May 2017 meeting. There was no designated physician documented as attending for him.	F 001	12 VAC 5-371-170 All residents have a potential to be affected by an absent physician. The facility's Medical Director remains the designated physician representative to attend quarterly meeting of the Quality Assurance Committee. However, the statement of required attendees has been revised to allow the Medical Director to designate an alternate physician if he/she cannot attend within the required time frame to meet compliance.	8-16-17

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F 001	Continued From Page 2 The meetings are held quarterly. The director of nurses and multiple other staff attend regularly. The director of nursing was asked if the physician attended all quarterly meetings, she stated, "No, sometimes he has an emergency and cannot attend." On 8/11/17 approximately 10:30 am, the administrative staff was informed of the concern. Prior to exit on 8/11/17, no further evidence was provided. The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12VAC 5-371-220 Based on staff interview and clinical record review the facility staff failed to provide the highest practical well- being to 1 of 6 residents in the survey sample. (Resident #6) The findings included: The facility staff failed to ensure appropriate assessment and documentation of a neurological assessment was performed for Resident #6. Resident #6 was admitted to the facility 7/10/14 with the following diagnoses of, but not limited to Parkinson's Disease, Atrial Fibrillation, cancer of the prostrate, neoplasm of the colon, pressure ulcer, urinary tract infection, pain and stroke. The surveyor performed a clinical record review of Resident #6's closed record on 8/10/17. According to the nursing notes dated for 5/9/17 at	F 001	12 VAC 5-371-220 All residents experiencing an unusual incident have a potential to be affected by inadequate documentation of the licensed medical professional on duty. An additional tool has been added to the facility's Electronic Health Record, in the form of a User Defined Assessment (UDA) template for neurological assessment to be included in the record. The shift's Nurse Supervisor will review documentation by the charge nurse of any unusual incident during his/her tour of duty. This will occur prior to ending his/her tour, or communicated to the next supervisor to complete, if necessary. Education to all licensed staff will be completed by 9/30/2017. Monitoring will be conducted by the Director of Nursing.	9.1.17

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F 001	Continued From Page 3 00:01 (12:01 am) the following note stated: "On assessment Resident was observed with a laceration approximately 3.5 cm (centimeters) x (by) 3 cm on his right eye brow which was bleeding. Ice pack applied to site. Dr (doctor) on call paged. Order received from NP (nurse practitioner) _____ (name of NP) covering for Dr. _____ (name of Dr.) Resident sent out via 911 to the _____ (name of hospital) ER ...T-98, P-88, R-20, BP-113/82 Notification: MD and POA (Power of Attorney) ...5/8/17 at 22:08 (10:08 PM) Telephone call received from _____ (name of hospital) that Resident had expired at 9:40 pm ..." The surveyor interviewed the director of nursing on 8/10/17 at 3 PM in the conference room. The surveyor asked the director of nursing to review the nurse's documentation regarding the dates of 5/8/17 when the resident had sustained a fall. The director of nursing reviewed the noted and stated "The resident fell earlier than what is charted in the nurses notes. I believe that she went to make a late entry but did not indicate this in this note." The surveyor asked the director of nursing if neurological assessments would have been appropriate to had been done when the resident fell. The director of nursing stated, "Yes, they would have been." The surveyor asked the director of nursing if any neurological assessments had been documented directly after the resident's fall. The director of nursing stated, "I will have to go and review the clinical record to see if there were any." The surveyor also requested a copy of the facility's policy regarding neurological assessments. At 5 PM, the director of nursing provided a copy of the facility's policy titled Neurological Assessments which stated: " ...3.1 Neurological assessments shall be	F 001		

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F 001	Continued From Page 4 performed on residents suspected of having neurological dysfunction, on all residents who have fallen and hit their head, and/or at risk of such. 3.2 Documentation regarding neurological assessments shall be located in the nurses' notes section of the clinical record ..." The director of nursing also provided the surveyor with a "Nursing Home to Hospital Transfer Form" which was dated for 5/8/17 and contained documentation of the medical history of Resident #6. It was also noted on this form the following documentation: " ...Vital signs: BP 134/82 HR 88 RR 20 Temp 98 O2 sat 93%...Reason for Transfer Fall ...Usual Mental Status: Alert, disoriented, but can follow simple instructions ..." The surveyor asked the director of nursing if a neurological assessment had been performed prior to the resident being transferred to the hospital after the fall. The director of nursing stated, "I cannot find anything documented as it had been performed by the nurse." The surveyor reviewed the facility's policy on "Neurological Assessments" which stated in part " ...Neurological Assessment- the assessment of neurological status includes: 1.1.1. Level of consciousness 1.1.2. Equality of pupil size and reaction to light 1.1.3. Sensorimotor responses ..." The surveyor asked the director of nursing if any of the above documented neurological assessments had been performed by the nurse and the director of nursing replied, "I cannot find where any of these were documented. So I would have to say that they were not done." The administrator and director of nursing were notified of the above documented findings on	F 001		

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F 001	Continued From Page 5 8/11/17 at 10 am by the surveyor. No further information was provided to the surveyor prior to the exit conference. The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12VAC 5-371-300 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to safely store medications during the medication pass and pour observation on 1 of 2 units in the nursing facility. On 8/10/17 at 9:30 am, the surveyor went to make a medication pass and pour observation with LPN (Licensed practical nurse) #1 on the 3rd floor of the facility. The surveyor observed LPN #1 place medications in a cup on top of the medication cart and cover them with another cup. These were left on top of the medication cart in the room right off from the nurses' station. The room did not have a door that could be locked. LPN #1 left these medications unattended while she went and administered medications to another resident in the dining area on the unit. These medications were administered to the resident in the dining area on the unit at 9:40 am. LPN #1 returned to the medication cart located in the room right off from the nurses' station and the surveyor asked what was under the covered cup on top of the cart. LPN #1 stated "When you came up and said you were here to watch me give out medicines, I left the ones that I was working on under the cup." The surveyor asked to see which medications were left under the cup. LPN #1 took out a pre-packaged bag that had a list of medications on it and LPN #1 compared these to	F 001	12 VAC 5-371-300 All residents have the potential to be affected by the presence of unsecured medications and substances. The medications were verified and administered to the appropriate resident with no negative outcome. Additional education on proper medication administration to all licensed staff will be completed with an emphasis on security awareness and potential access. The Director of Nursing, Nursing Supervisors and Administrator will check for unsecured items during daily rounds. Infractions will be reported to the Director of Nursing and reported at the quarterly Quality Assurance meeting. RECEIVED SEP 15 2017	9.1.17

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F 001	Continued From Page 6 the ones in the cup. LPN #1 stated "these were the ones I was working on to give to another resident." The following medications were identified by LPN #1 was the medications left unattended under the cup on the medication cart: "Tylenol ER (Extended Release) 650 mg (milligram) 1 tablet, ASA (Aspirin) 81 mg 1 tablet, Metoprolol 25 mg 1 tablet, Omeprazole 20 mg 2 tablets and Trospium ER 60 mg 1 tablet." The surveyor asked LPN #1 if the medications should had been left unattended. LPN #1 replied, "No, I should had either gave the resident the medication before starting with you or I should had locked them up in the medication cart." At 10:30 am, the surveyor requested a copy of the facility's policy regarding medication storage from the social worker. At 10:40 am, the social worker provided a copy of the policy titled "Medication Storage." Under the section of "Policy Interpretation and Implementation" the policy stated: " ...2. Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications ...are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access ..." The administrative team was notified of the above documented findings by the surveyor on 8/11/17 at approximately 10:15 am. No further information was provided to the surveyor prior to the exit conference on 8/11/17.	F 001		