PRINTED: 02/11/2016
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. BUILDING _____ B. WING _____	02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON NURSING AND REHABILITATION CENTER	8111 TISWELL DRIVE ALEXANDRIA, VA 22306

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/1/16 through 2/3/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated. The census in this 98 certified bed facility was 86 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #1 through #13) and 5 closed record reviews (Residents #14 through #18).	F 000	The statements made in this plan of correction are not an admission to and do not constitute an agreements with the alleged deficiencies. The remain in compliance with all federal and State regulations, the center has taken or will take the Actions set forth in this plan of correction. The plans of correction constitutes the centers allegation of complaince such that all alleged deficiencies cited have been or will be corrected by the dates or dates indicated.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed for 1 resident (Resident #7) in the survey sample of 18 residents, to ensure that the resident was free of a physical restraint. The facility staff failed to ensure that Resident #7 was free of a physical restraint (full bed siderails). The Findings included: Resident #7 was a 54 year old who was admitted to the facility on 10/8/89. Resident #7's diagnoses	F 221	1.Resident #7 had no adverse effects, and corrective action was immediately taken, resident's side rails were removed, he has a perimeter defining mattress, low bed and floor mats. 2.All residents receiving care have the potential to be affected. 3.The facility will conduct an audit of all residents to assure there are no full side rails on any remaining beds. a. Provide Education to all staff on the definition of restraints. 4. In order to assure on going to complaince the facility will conduct a weekly x4 weeks and monthly x4 months. 5. All finding will be submitted to QAA for review and recommendations. 6. The Corrective action will be completed by 2/26/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: Feb 18, 2016

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

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included History of Brain Injury, Hemorrhage of Cerebrum, Elbow Contracture, Muscle Weakness, and Hemiplegia (1 sided weakness).

The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 11/18/15, coded Resident #7 as having Severely Impaired Cognition, and as requiring the extensive assistance of 2 persons for transfers.

On 2/1/16 at 2:15 P.M. a tour of the facility was conducted. Resident #7 was observed to be lying in his bed, which was in its lowest position, with both full side rails up. In addition, he had a scoop mattress and fall mats on the floor on both sides of his bed.

On 2/2/16 a review was conducted of Resident #7's clinical record, revealing the following signed physician's order, "2/1/16. 2 side rails on bed - unable to define parameters of bed. Check safety device every 2 hours when in use. Start date 10/10/13."

Resident #7's clinical record contained only 2 assessments of his need for full bed rails, one was 10 years old, and the other one was 5 years old. They read, 1. "1/17/06. Continues to benefit from 2 full side rails allowing freedom to move around in bed. Full side rails have been in effect since admission and successful in preventing fall/injury." 2. "9/12/11. Though the resident may benefit from the side rails to help the resident determine the bed parameters and thereby preventing his rolling of the bed, yet the IDT (Interdisciplinary Team) determines it also has risks to the resident and may also affect his psychosocial well-being. These risks may include entrapment and restraining the resident's free

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movement in and out of bed. Therefore the IDT has recommended the discontinuation of the side rail use; a recommendation that has been strongly argued against by the Representative Payee. The IDT is left with no other recourse but to accept the RP's recommendation at this point and allow the siderails to remain in use until another routine assessment is completed."

On 2/2/16 at 9:00 A.M. another observation was made of Resident #7 lying in his bed with both full side rails up, a scoop mattress, bed in lowest position, and floor mats on both sides of the bed.

On 2/2/16 at 4:00 P.M. an interview was conducted with the MDS Coordinator (Other A), he stated that he has worked with Resident #7 for 16 years. When asked why Resident #7's use of Bed side rails was not coded on the MDS, and why the side rails were in use, Other A stated, "the rails are not a restraint because he cannot get out of bed by himself. When he gets angry he tries to shake and throw himself out of bed. His father used to be able to calm him down, but his father died a few years ago. We don't know what makes him angry. No behavioral care plan has been developed. " Other A also stated that the facility had not tried less restrictive methods prior to implementing the use of full side rails.

Resident #7's care plan was reviewed. The plan did not address his behaviors and need for side rails. The care plan read, "Use of full side rails for safety as related to Traumatic Brain Injury causing impaired safety awareness and involuntary movement of extremities 11/29/15."

On 2/2/16 at 4:30 P.M. the facility Administrator (Administration A), and Director of Nurses

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F 221	Continued From page 3 (Administration B) were informed of the findings. The Administrator provided the surveyor with measurements of the bed rails. They were 64 inches long, 10 inches high, metal bars in the shape of a grid. there were six five inch high openings in bars, in which a Resident #7's arm or leg could have easily gone through, causing potential entrapment and injury.	F 221		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed, for 1 resident (Resident #7)	F 279	1. Resident #7 had no adverse effect. Immediate corrective action was taken. 2. All residents receiving care have the potential to be affected. 3. The facility will conduct an audit of all residents with documented behaviors to assure there is a behavior care plan in place. 4. The facility will provide re- education to the staff to define behaviors 5. The facility will institute a new process to assure that all residents with behaviors have an appropriate behavior care plan via IDT Behavior Note. 6.In order to assure on going compliance the facility will conduct a random audit of 4 recors. This audit will be conducted weekly x 4 weeks and monthly x4 months. 7. All findings will be submitted to QAA for review and recommendations. 8. The corrective action will be completed by 2/26/16	

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in the survey sample of 18 residents, to develop a Comprehensive Care Plan.

For Resident #7, the Facility staff failed to develop a Behavioral Care Plan for safety while in bed.

The Findings included:

Resident #7 was a 54 year old who was admitted to the facility on 10/8/89. Resident #7's diagnoses included History of Brain Injury, Hemorrhage of Cerebrum, Elbow Contracture, Muscle Weakness, and Hemiplegia (1 sided weakness).

The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 11/18/15, coded Resident #7 as having Severely Impaired Cognition, and as requiring the extensive assistance of 2 persons for transfers.

On 2/1/16 at 2:15 P.M. a tour of the facility was conducted. Resident #7 was observed to be lying in his bed, which was in its lowest position, with both full side rails up. In addition, he had a scoop mattress and fall mats on the floor on both sides of his bed.

On 2/2/16 a review was conducted of Resident #7's clinical record, revealing the following signed physician's order, "2/1/16. 2 side rails on bed - unable to define parameters of bed. Check safety device every 2 hours when in use. Start date 10/10/13."

Resident #7's clinical record contained only 2 assessments of his need for full bed rails, on was 10 years old, and the other one was 5 years old. They read, 1. "1/17/06. Continues to benefit from

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2 full side rails allowing freedom to move around in bed. Full side rails have been in effect since admission and successful in preventing fall/injury." 2. "9/12/11. Though the resident may benefit from the side rails to help the resident determine the bed parameters and thereby preventing his rolling of the bed, yet the IDT (Interdisciplinary Team) determines it also has risks to the resident and may also affect his psychosocial well-being. These risks may include entrapment and restraining the resident's free movement in and out of bed. Therefore the IDT has recommended the discontinuation of the side rail use; a recommendation that has been strongly argued against by the Representative Payee. The IDT is left with no other recourse but to accept the RP's recommendation at this point and allow the side rails to remain in use until another routine assessment is completed."

On 2/2/16 at 9:00 A.M. another observation was made of Resident #7 lying in his bed with both full side rails up, a scoop mattress, bed in lowest position, and floor mats on both sides of the bed.

On 2/2/16 at 4:00 P.M. an interview was conducted with the MDS Coordinator (Other A), he stated that he has worked with Resident #7 for 16 years. When asked why Resident #7's use of Bed side rails was not coded on the MDS, and why the side rails were in use, Other A stated, "the rails are not a restraint because he cannot get out of bed by himself. When he gets angry he tries to shake and throw himself out of bed. His father used to be able to calm him down, but his father died a few years ago. We don't know what makes him angry. No Behavioral Care Plan has been developed. " Other A also stated that the facility had not tried less restrictive methods prior

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F 279	Continued From page 6 to implementing the use of full side rails. Resident #7's Care Plan was reviewed. The plan did not address his behaviors and need for side rails. The Care Plan read, "Use of full side rails for safety as related to Traumatic Brain Injury causing impaired safety awareness and involuntary movement of extremities 11/29/15." On 2/2/16 at 4:30 P.M. the facility Administrator (Administration A), and Director of Nurses (Administration B) were informed of the findings. On 2/3/16 at 10:00 A.M. the facility Administrator stated that the side rails had been removed from the bed, which was subsequently confirmed by an observation by the surveyor.	F 279		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to supervise one Resident while toileting (Resident #15) in the survey sample of 18 residents, and failed to ensure the treatment room was locked. 1. For Resident #15, after experiencing multiple	F 323	Part 1 1. Resident #15 is no longer in the facility. 2. All residents receiving care have the potential to be affected. 3. The facility will insitiute a new task on POC for 1:1 needs. 4. The staff will be educated on the new process. 5.In order to assure on going complaince the facility will conduct a random audit weekly x 4 weeks and monthly x 4 months. 6. All findings will be submited to QAA for review and rcommendations. 7. The corrective action will be completed by 2/26/16.	

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previous falls due to the Resident rising and attempting to walk unassisted to the bathroom, or from the bathroom back to bed, the facility staff failed to supervise the resident while toileting, and the Resident fell on 2/17/15 at 2:30 PM and was sent out to the emergency room with bruises to his head.

2. The second floor treatment room door was not locked. It was observed propped open. Lancets, blood collection needles and medications were stored in the room.

The findings included:

1. Resident #15 was added to the survey sample as part of a complaint investigation that was conducted during the course of the survey. One of the allegations in the complaint was regarding failure of the facility to assess and monitor a Resident.

Resident #15, was initially admitted to the facility on 8-6-13, and readmitted on 3-6-14. Diagnoses included; Urinary obstruction and retention, hypertension, depression, atrial fibrillation, diabetes, arthritis, falls, and stroke (CVA).

Resident #15's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-21-15, was coded as a quarterly assessment. Resident #15 was coded as able to make own daily life decisions. Resident #15 was coded as requiring extensive assistance of one staff member to perform ambulation, transferring and toileting, and was frequently incontinent of bowel and bladder. Resident #15 was coded as having one fall with no injury since readmission on 3-6-14, however, the care plan revealed that the

1. No residents were affected.

2. All residents have the potential to be affected.

3.Immediate corrective action was taken.

4. The plastic treatment cart was removed from the treatment room.Signs were placed on all medication and treatment room doors.

5. The staff will be educated on potential hazards and processes to prevent reocurrence.

6. In order to assure ongoing complaince the facility will conduct a random audit weekly x 4 weekly and monthly x 4 months.

7.All findings will be submitted to QAA for review and recommendations.

8. The corrective action will be completed by 2/26/16

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Resident had numerous falls, after the most recent readmission, occurring on 5-25-14, 6-18-14, 6-30-14, 12-23-14. The most recent fall occurred on 2-17-15, after the MDS completion.

Resident #15 was a closed record review, and it was found that the resident expired on 4-11-15, so was not able to be observed.

Resident #15's care plan was reviewed and included under the heading of "Focus", "Resident at risk for falls related to confusion, visual impairment, generalized weakness, and decreased mobility." Under the heading of "Interventions" listed " "CNA's not to leave resident unattended when toileting." Initiated 6-18-14. The care plan also included "Notify MD (doctor), and RP (Responsible Party) of any changes." initiated on 1-5-15.

Review of Resident #15's clinical record revealed entries in the nurses' notes that included the following entries:

On 2-16-15, the day before the fall, it was noted that the Resident had a low blood sugar and was given orange juice to treat it, was diagnosed with an drug resistant bacterial infection of a wound, had been placed in isolation because of the infection, which meant a room change, and started on an antibiotic medication. Any or all of these predisposing factors increase the likelihood of falls in the elderly, especially those with a history of falls.

"2-17-15 2:35 p.m"., Neurological checks had been performed after the Resident was observed lying on the floor outside the resident's bathroom. "CNA (certified nursing assistant) had placed

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resident on toilet with instructions to use red call light when finished." The CNA left the room. The note goes on to describe that the CNA removed the wheelchair from the bathroom, in an attempt to prevent the resident from transferring himself, and falling. It was known that the Resident had fallen multiple times in the past, as described in the care plan, when toileting, and the intervention of CNA's not leaving him alone while on the toilet was instituted. The nursing note goes on to say there were no injuries, and that he was found on the floor with his head laying on the foot pedal of an "Isolation container" (trash can). The exact time of the fall was documented as 2:30 p.m.

On 2-17-15 at 4:23 p.m. the Resident's son (responsible party) arrived to visit with the Resident and stated his father was complaining of neck and back pain and vomiting. The nursing supervisor was brought in by staff to talk to the son who was insisting that the Resident be sent to the hospital for evaluation. The son called 911, as the staff had not, and the staff gave the son requested documents to send to the hospital with the Resident.

On 2-17-15 at 9:14 p.m. the Resident returned from the hospital with diagnoses of Multiple contusions (bruises) headache & trauma, as documented on the Hospital notes which were reviewed.

Review of the facility's fall investigation completed for the fall on 2-18-15 revealed that the doctor and Responsible Party were notified as of 2-18-15 when the report was completed. This is the only indication that notification was made. The son's presence after the fall, and his subsequent insistence that the Resident be sent

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to the hospital, after the son was aware of the fall, indicates no previous notice was given to the family, as the family had stated.

The facilities fall investigation document did not reveal any injuries post fall/accident, but the hospital records did indicate that there was bruising to the head. The investigation report was a computer generated check list, and gave options for predisposing factors, including; "incontinence, recent change in condition, recent illness, recent changes in medications/new, other (infections), and toileting. None of these were documented as factors, even though the nursing notes documented all of them as present on 2-16-15, the day before the most recent fall, and the most recent MDS documented incontinence.

On 2-3-16 at 9:00 a.m., when interviewed, The Director of Nursing (DON) RN (registered nurse) stated that the Resident was left alone by the CNA, and she was aware that the care plan had been instituted to prevent this.

The Administrator, DON (director of nursing), and ADON (Assistant Director of Nursing) were advised of the failure of the staff to provided adequate supervision to prevent an accident for Resident #15. No further information was provided.

2. The second floor treatment room door was not locked. It was observed propped open. Lancets, blood collection needles and medications were stored in the room.

On 2/2/16 at 8:50 a.m., the "treatment" room door on the second floor was observed to be propped open. Against the left wall of the treatment room

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was a cart made of white, plastic pipe. The cart included a plastic arm that moved on a hinge. The arm was propped between the door and the door frame so that the door would not close or lock. No residents were observed in the immediate area.

The treatment room contained the following items:
Blood collection needles (BD vacutainer brand): 7 boxes (48 count), on counters/ in drawers
Lancets: 1 box, on open shelf
Biohazard refrigerator: contained 1 blood specimen and 1 fecal specimen
Voltaren gel (for pain)- full tube
Hysept solution (solution used to kill bacteria)- 2 full bottles
Hydrogel (used to keep wounds moist)- (1) 4 ounce tube

At 9:02 a.m., the Director of Nursing (DON) was asked if the door was supposed to be propped open. She stated no. She stated the cart was not in use because it had been replaced. The DON was shown the medications in the cart. She stated that the medications should not be in the cart. She checked the medication labels and stated that the medications belonged to residents who had been discharged. When asked how long ago the resident using the Voltaren gel was discharged, the DON stated 6 months.

At 9:08 a.m., the DON asked the Assistant Director of Nursing (ADON) about the cart and the medications. The ADON stated that the medications that were in the cart needed to be discarded. When asked how often the medications should be discarded, the ADON stated every month or every other month.

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F 323	Continued From page 12 The DON also looked at the specimens in the biohazard refrigerator. She stated that the samples had been put into the refrigerator that morning. She thought that it was possible the staff who had put the samples in the refrigerator had propped the door. No unlocked or propped doors were observed at any other time during the survey. The Administrator and DON were notified of the issue with the propped door at the end of day meeting on 2/2/16.	F 323		
F 371 SS=E	COMPLAINT DEFICIENCY 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview the facility staff failed to prepare and serve food in a sanitary manner. The facility staff failed to effectively wear hair restraints while preparing and serving food.	F 371	1.No Residents or Patients had adverse effects. 2. All residents receiving consumable food products have the potential to be affected. 3. The facility will provide education to all dietary personnel on proper usage of hair restraints and how to properly cover all facial and body hair. 4.To assure on going complaince the facility will conduct daily audits on all dietary personnel. 5. In order to assure ongoing complaince, the facility will conduct random audits of personnel in the kitchen weekly x 4 and then monthly x 4	

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F 371	Continued From page 13 The Findings included: On 2/2/16 at 11:45 A.M. an observation was conducted of the facility's Kitchen. A Dietary Aide (Other D) was preparing foods during tray line. Other D's hairnet was not on properly. She had approximately 3" of hair hanging down from the right rear of her head. In addition, another Dietary Aide, Other C was not wearing a hair restraint on his mustache and beard. His facial hair was approximately one-half inch long. Other C leaned over every food container as he took the temperatures. When asked if he had access to a beard restraint, Other C stated, "There's one in that other room. I forgot to put one on now" On 2/2/16 a review was conducted of the facility's Hair Restraints Policy (undated). It read, "Food Employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair and worn to effectively keep the hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles." On 2/2/16 at 4:30 P.M. the Director of Nursing (DON-Administration B), and the Administrator (Administrator A) were notified of the findings. No further information was received.	F 371	6. All findings will be submitted to QAA for review and recommendations. 7. The corrective action will be completed by 2/26/16.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 14 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review,	F 431	1. No residents were affected. 2. All residents have the potential to be affected. 3. Immediate corrective acation was taken. 4.The faicility will institute a new process, where the night shift RN supervisor will audit medication refrigerators and IV boxes nighlty for expiration dates. 5. The staff will be educated on the new process. 6. In order to assure on going complaince the facility will conduct a random audit weekly x 4 weeks and monthly x 4 months. 7. All findings will be submitted to QAA for review and recommendations. 8. The corrective action will be completed by 2/26/16.	

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the facility staff failed to ensure that one of two medication rooms (Second Floor medication room) was free of expired medications and Intravenous fluids

1. In the Medication Room on Unit 2, the facility staff failed to ensure that expired intravenous fluids and medication were not available for use.

Findings included:

On 2/2/2016 at 3:40 PM., an inspection of the Medication Room on the second floor was conducted with Evening Shift Supervisor Registered Nurse C (RN C). Two expired Intravenous Solutions were observed in the IV (intravenous) box:
1000 milliliter bag of 5 percent Dextrose in Water Expiration Date August 2015
1000 milliliter bag of Sodium Chloride expiration date November 2015

An expired bottle of Flu vaccine was observed in the refrigerator: Fluvirin multidose vial Expiration June 2015

On 2/2/2016 at 3:45 PM, an interview was conducted with RN C (Registered Nurse C) who stated "the facility ordered single dose Flu vaccines this year. Separate syringes were used this year. Night shift nurses are responsible for checking the medications in the refrigerator. RN C stated the "Pharmacy is in charge of checking IV solutions and making sure they are available for the facility." RN C also stated the "IV box was just delivered today (2/2/2016) with the expired IV fluids." When asked about the expectation regarding medications, RN C stated the nurses should check the expiration date prior to giving

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F 431	Continued From page 16 any medications or IV fluids. The expired medication was removed from the refrigerator and the expired IV fluids were removed from the IV box. On 2/2/2016 during the end of day debriefing at approximately 4:15 PM, the Director of Nursing (DON), Administrator and Assistant Director of Nursing were informed of the findings of expired medications and IV fluids in the second floor medication room. The Director of Nursing stated she had been informed by the evening shift supervisor and was surprised that the IV fluids were expired since Pharmacy just delivered the box. The DON stated the expectation was that the Pharmacy should check the expiration dates of all medications and IV fluid prior to delivering to the facility and nurses should check the expiration dates prior to administering medications or IV fluids. The facility staff did not present any further information regarding the findings.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	1. Resident # 4 had no adverse effects. Immediate action was taken. 2. All residents receiving care have the potential to be affected. 3. The facility will institute a new infection control policy. a. There will be an isolation task added to POC to alert CNA's when a resident is on islolation. b. The isolation care plans will be updated to reflect type of isolations and this will be reflected on the CNA's kardex. 4. The staff will be educated on the new process.	

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F 441	Continued From page 17	F 441	5. In order to assure on going complaince the facility will conduct a random audit weekly x 4 weeks and monthly x 4 months. 6. All findings will be submitted to QAA for review and recommendations. 7. The corrective action will be completed by 2/26/16.	

should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, resident interview, facility documentation review and clinical record review, the facility staff failed to implement infection control procedures for one resident (Resident #4) in a survey sample of 18 residents.

For Resident #4, the CNA did not wear gloves, or properly apply a gown while providing care to Resident #4, who was under Isolation Contact precautions for an active Clostridium Difficile

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(C-Diff) communicable infection. The facility did track infections, however, the facility had no trending and quality initiatives, and also failed to have an effective infection control program to include policies and procedures to help prevent the development and transmission of disease and infection.

http://www.cdc.gov/HAI/organisms/cdiff/Cdiff_excerpt.html

Clostridium difficile "is an anaerobic, gram-positive bacterium" causing diarrhea and the organism can be spread to others by hands of health-care workers; wearing gloves and proper handwashing remains the most effective means of reducing contamination. Please refer to the above website for more information.

The findings included;

Resident #4, was admitted to the facility on 1-30-16. Diagnoses included C-Diff enterocolitis infection placed in isolation and on contact precautions for communicable disease upon admission to the facility, Lung cancer, Neutropenia, hypertension, high cholesterol, anemia, depression, and (COPD) chronic obstructive pulmonary disease.

Resident #4's most recent MDS (minimum data set) was an admission assessment and had not been completed as the Resident had only been admitted for 3 days at the time of survey.

On 2-2-16 at 9:00 AM, the Resident was observed in bed receiving care from certified

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nursing assistant (CNA) B, and was interviewed. CNA B was observed to be wearing a mask, and a yellow, thin paper fiber isolation gown which was not tied in the back, so that the gown flapped to the side and allowed the CNA's clothing to come in contact with the bed and the Resident. CNA B was not wearing gloves. The CNA was touching the bed with her legs as she leaned over the Resident, touching the Resident's legs with her hands as she repositioned them under the bed linens, and touching the bed linens with her bare hands when she pulled them up to recover the Resident.

Resident #4's care plan was reviewed and revealed that the Resident was in isolation and under contact precautions for C-Diff. Also noted were interventions to protect Resident #4 related to her Cancer and Radiation therapy, which were special universal precautions to include glove use in order to prevent and protect Resident #4 from coming into contact with harmful pathogens from others, because of a compromised immune system related to her cancer.

Review of the facility "Isolation" policy revealed "At minimum, contact precautions should be followed for all residents. Protective equipment (gloves, gowns, mask) should be available and worn upon entering the room."

On 2-2-16 immediately after the observation, CNA B left the Resident's room during the surveyor interview with the Resident. On 2-2-16 at 9:30 a.m. the Director of Nursing (DON) was interviewed on the same floor during observation of the treatment room, and told of the breach of infection control procedures by CNA B. The DON stated that CNA B told her about the observation,

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and stated that she had only touched the side rails of the bed when she put them up, and the bed linens without gloves. The DON stated she told CNA B that gloves should be worn at all times in this room. It is notable to mention that no side rails were up on the bed during the interview, and had not been put up at 9:30 a.m. when the surveyor went back to the room after the interview with the DON. The DON was asked for the infection control program policies.

On 2-3-16 at approximately 10:00 AM, the infection control program was reviewed with the RN (Registered Nurse) D (infection control nurse) who provided 5 one page policies, all of which were specific instructions on obtaining cultures, and discontinuing isolation when appropriate. The only policy which dealt with infection control procedures was the Isolation Policy, which did not include surveillance, recognition, investigation, prevention, limiting employees with communicable disease access to residents, proficiency and observation of staff practices, and quality improvement measures. No written program for infection control was presented. The only 5 policies that the facility had were as follows:

1. Isolation Policy (mentioned above)
2. C-Diff Policy
3. ESBL's (extended spectrum beta lactamase) or MDRO's (multi-drug Resistant organism's) Policy
4. MRSA (methycillin resistant staphylococcus aureus) Policy (also an MDRO)
5. VRE (vancomycin resistant enterococcus) Policy (also an MDRO)

RN D provided a tracking form listing all of the in

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house infections, however, no trending or Quality Assurance or improvement initiatives had been planned as a result of the tracking.

Registered Nurse (RN) D stated that is all the policies we have. RN D also stated, "We counseled the CNA after you identified the infection control breach." When RN D was asked for credible evidence of re-education for CNA B, he stated he didn't have any. He went on to say that they institute changes if problems are found with infection control, and he did not have any examples of changes they had made in their quality assurance program for infection control. He was asked how they identify problems in their infection control program, and if they were conducting rounds and observations of staff practices. RN D stated that they were not.

The CNA providing care for this Resident was unaware of the correct isolation protocols for contact precautions, and the facility was not conducting rounds to identify lapses in the staff infection control practices.

On 2-3-16 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings. The DON and Administrator stated that the policies had been inherited from the former administration and needed to be improved. They further stated that they would be developing a new infection control program this year. No further information was provided.

F 498 SS=D 483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS

The facility must ensure that nurse aides are able

F 498 1. No residents were affected.

2. All residents receiving care have the potential to be affected.

3. Immediate corrective action was taken.

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to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure a CNA (Certified Nursing Assistant) was proficient in carrying out infection control procedures for 1 Resident (Resident #4) of 18 residents in the survey sample.

For Resident #4, the CNA did not wear gloves, or properly apply a gown while providing care to the Resident who was under Isolation Contact precautions for an active Clostridium Difficile (C-Diff) communicable infection.

The findings included;

Resident #4, was admitted to the facility on 1-30-16. Diagnoses included C-Diff enterocolitis infection, placed in isolation and on contact precautions for communicable disease upon admission to the facility, Lung cancer, Neutropenia, hypertension, high cholesterol, anemia, depression, and (COPD) congestive obstructive pulmonary disease.

Resident #4's most recent MDS (minimum data set) was an admission assessment and had not been completed as the Resident had only been admitted for 3 days at the time of survey.

On 2-2-16 at 9:00 AM, the Resident was observed in bed receiving care from CNA B, and

F 498

4. The facility will institute a new process which will begin on orientation for CNA competency/ care needs.

a. CNA education for isolation will be reviewed and updated.

b. Current CNA saff will have a review of the isolation policies annually.

5. The facility staff will be educated on the new process.

6. In order to aaure on going compliance the facility will conduct a random audit weekly x 4 weeks and monthly x 4 months.

7. All finding will be submitted to QAA for review and recommendations.

8. The corrective action will be completed by 2/26/16.

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was interviewed. CNA B was observed to be wearing a mask, and a yellow, thin paper fiber isolation gown which was not tied in the back, so that the gown flapped to the side and allowed the CNA's clothing to come in contact with the bed and the Resident. CNA B was not wearing gloves. The CNA was touching the bed with her legs as she leaned over the Resident, touching the Resident's legs with her hands as she repositioned them under the bed linens, and touching the bed linens with her bare hands when she pulled them up to recover the Resident.

Resident #4's care plan was reviewed and revealed that the Resident was in isolation and under contact precautions for C-Diff. Also noted were interventions to protect Resident #4 related to her Cancer and Radiation therapy, which were special universal precautions to include glove use in order to prevent and protect Resident #4 from coming into contact with harmful pathogens from others, because of a compromised immune system related to her cancer.

Review of the facility "Isolation" policy revealed "At minimum, contact precautions should be followed for all residents. Protective equipment (gloves, gowns, mask) should be available and worn upon entering the room.

On 2-2-16 immediately after the observation, CNA B left the Resident's room during the surveyor interview with the Resident. On 2-2-16 at 9:30 a.m. the Director of Nursing was interviewed on the same floor during observation of the treatment room, and told of the breach of infection control procedures by CNA B. The DON stated that CNA B told her about the observation, and stated that she had only touched the side

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rails of the bed when she put them up, and the bed linens without gloves. The DON stated she told CNA B that gloves should be worn at all times in this room. It is notable to mention that no side rails were up on the bed during the interview, and had not been put up at 9:30 a.m. when the surveyor went back to the room after the interview with the DON. The DON was asked for the infection control program policies.

On 2-3-16 at approximately 10:00 AM, the infection control program was reviewed. with the RN (Registered Nurse) D (infection control nurse) who provided 5 one page policies, all of which are specific instructions on obtaining cultures, and discontinuing isolation when appropriate. The only policy which deals with infection control procedures is the Isolation Policy, which does not include surveillance, recognition, investigation, prevention, limiting employees with communicable disease access to residents, proficiency and observation of staff practices, and quality improvement measures. No written program for infection control was presented. The only 5 policies that the facility had are as follows;

1. Isolation Policy (mentioned above)
2. C-Diff Policy
3. ESBL's (extended spectrum beta lactamase) or MDRO's (multi-drug Resistant organism's) Policy
4. MRSA (methycillin resistant staphylococcus aureus) Policy (also an MDRO)
5. VRE (vancomycin resistant enterococcus) Policy (also an MDRO)

RN D stated that is all the policies we have. RN D also stated, "We counseled the CNA after you

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. BUILDING _____ B. WING _____	02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON NURSING AND REHABILITATION CENTER	8111 TISWELL DRIVE ALEXANDRIA, VA 22306

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 498	Continued From page 25	F 498		

identified the infection control breach." When RN D was asked for credible evidence of re-education for CNA B, he stated he didn't have any. He went on to say that they institute changes if problems are found with infection control, and he did not have any examples of changes they had made in their quality assurance program for infection control. He was asked how they identify problems in their infection control program, and if they were conducting rounds and observations of staff practices. RN D stated that they were not.

The CNA providing care for this Resident was unaware of the correct isolation protocols for contact precautions, and the facility was not conducting rounds to identify lapses in the staff infection control practices.

On 2-3-16 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings. The DON and Administrator stated that the policies had been inherited from the former administration and needed to be improved. They further stated that they would be developing a new infection control program this year. No further information was provided.

MT. VERNON
NURSING & REHAB CENTER
RESTORING LIFE'S BALANCE

February 18, 2016

Ms. Elaine Cacciatore
LTC Supervisor
VDH – Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive, Suite 401
Richmond, VA 23233-1463

Plan of Correction for Mt. Vernon Nursing and Rehabilitation Center
Survey Date: February 1 -3, 2016

Dear Ms. Cacciatore,

Enclosed please find our facility POC from our Survey ending February 3, 2016. I will also, as requested, complete a Survey Response Form.

Very truly yours,

Robert K. DeMaria
Administrator

Enclosure 2567 POC

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FEB 19 2016
VDH/OLC

8111 Fort Wells Drive • Alexandria, VA 22306 • ph: 703.360.4000 • fax: 703.780.6438
www.mvnrc.net

COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

February 11, 2016

Mr. Robert Demaria, Administrator
Mount Vernon Nursing And Rehabilitation Center
8111 Tiswell Drive
Alexandria, VA 22306

RE: Mount Vernon Nursing And Rehabilitation Center
CCN: 495211

Dear Mr. Demaria:

An unannounced standard survey, ending February 3, 2016, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. One complaint was investigated during the survey. One complaint was substantiated, with deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of F), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Elaine Cacciatore, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233.
To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at "http://www.vdh.state.va.us/OLC/longtermcare/".

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).

- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,

- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: "http://www.vdh.state.va.us/OLC/longtermcare/". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Elaine Cacciatore

Elaine Cacciatore, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman
Jaime Desper, D M A S (Sent Electronically)