PRINTED: 02/11/2016 FORM APPROVED

DEPART	WENT OF HEALTH	MAD HONGIN OF MACES			OMB NO. 0938-0391
CENTERS FOR MEDICARE & ME STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PF		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
Address of the Avenue		495211	B, WING		02/03/2016
	PROVIDER OR SUPPLIER VERNON NURSING A	NO REHABILITATION CENTER	81	TREET ADDRESS, CITY, STATE, ZIP CODE 111 TISWELL DRIVE LEXANDRIA, VA 22306	
(X4) ID PREFIX TAG	(EACH DEBICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	PREFIX TAG	PROVIDER'S FLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 000	survey was conduct Corrections are red CFR Part 483 Feder requirements. The survey/report will for investigated.	Medicare/Medicaid standard ted 2/1/16 through 2/3/16, pulred for compliance with 42 eral Long Term Care Life Safety Code Illow. One complaint was	F 000	The statements made in this pare not an admission to and do an agreements with the aliege. The remain in compliance with State regulations, the center hake the Actions set forth in this The plans of correction constituallegation of complaince such deficiencies cited have been on by the dates or dates indicated.	o not constitute d deficiencies. all federal and as taken or will is plan of correction. utes the centers that all alleged ir will be corrected
F 221 SS=D	at the time of the si consisted of 13 cur (Residents #1 throut reviews (Residents 483.13(a) RIGHT T PHYSICAL RESTR The resident has the physical restraints in discipline or conver-	urvey. The survey sample rent Resident reviews ugh #13) and 5 closed record #14 through #18). TO BE FREE FROM	F 221	1. Resident #7 had no adverse effects corrective action was immediately tak resident's side rails were removed, he perimeter defining mattress, low bed mats. 2. All residents receiving care have the affected.	en, : has a and floor
	by: Based on observa documentation revi the facility staff faile in the survey samp that the resident we The facility staff faile	NT is not met as evidenced tion, staff interview, facility ew, and clinical record review, ed for 1 resident (Resident #7) le of 18 residents, to ensure as free of a physical restraint. ed to ensure that Resident #7 cal restraint (full bed sideralls).		3. The facility will conduct an audit of a to assure there are no full side rails of remaining beds. a. Provide Education to all st definition of restraints. 4. In order to assure on going to complicatifity will conduct a weekly x4 week monthly x4 months. 5. All finding will be submitted to QAA and recommendations. 6. The Corrective action will be completed.	aff on the ofsince the s and
	Resident #7 was a	54 year old who was admitted 8/89. Resident #7's diagnoses		а. тие соптестуе астоп мягре сотпр	aloo by ereor to

ECTORS OR PROVIDENSHIPFLIER BEPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asteries () 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.

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: RSMQ11

RECEIVED Continuation sheet Page 1 of 26 Facility ID: VA0188

(X8) DATE



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

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

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	495211	B. WING		02/03/2016
NAME OF PROVIDER OR SUPPLIER MOUNT VERNON NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8111 TISWELL DRIVE ALEXANDRIA, VA 22306	
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION

F 221 Continued From page 1

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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A MEDIO, NO GENERALIE DE LEDICITA	(X2) MULTIPL	(X3) DATE SURVEY	
IDENTIFICATION NUMBER:	` '		COMPLETED
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495211	B. WING		02/03/2016
ANAR OF SPONIOLD OF SHOOT ED		TREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER		111 TISWELL DRIVE	
ND REHABILITATION CENTER	A	LEXANDRIA, VA 22306	
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495211 B. WING S IND REHABILITATION CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL (X2) MULTIPL A. BUILDING B. WING B. WIN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495211 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8111 TISWELL DRIVE ALEXANDRIA, VA 22306 TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) (X2) MULTIPLE CONSTRUCTION A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 8111 TISWELL DRIVE ALEXANDRIA, VA 22306 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRI

F 221 Continued From page 2

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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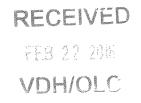
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495211	B. WING		02/03/2016
	PROVIDER OR SUPPLIER VERNON NURSING A	AND REHABILITATION CENTER	J	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 TISWELL DRIVE ALEXANDRIA, VA 22306	
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F 279 ° SS≖D °	The Administrator preasurements of the inches long, 10 inches long, in bars, in leg could have easi potential entrapment 483.20(d), 483.20(inches long). COMPREHENSIVE A facility must use the to develop, review a comprehensive plant of each reside objectives and time medical, nursing, and needs that are identical, nursing, and inches that are identical assessment. The care plan must to be furnished to a highest practicable psychosocial well-be §483.25; and any set be required under §483.10, including the under §483.10, including the third second legislation of the resident's §483.10, including the under §483.10(b)(4). This REQUIREMENT is seen the second legislation of the resident's §483.10 including the under §483.10 including the legislation of the resident's §483.10 including the under §483.10 including the legislation of the legislati	were informed of the findings. provided the surveyor with the bed rails. They were 64 whes high, metal bars in the are were six five inch high in which a Resident #7's arm or ally gone through, causing and and injury. (k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's and revise the resident's and revise the resident's and mental and psychosocial antified in the comprehensive at describe the services that are attain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment	F 27		of all residents with there is a behavior tion to the staff to define the define the define the define the facility will the control of the facility will be control of the facility will
		d. for 1 resident (Resident #7)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RSMQ11

Facility ID: VA0188

If continuation sheet Page 4 of 26



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		E & MEDICAID SERVICES		No-restricted to			VO. 0938-039
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		495211	B. WING	}	- Published		02/03/2016
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MOUNT	VERNON NURSING A	AND REHABILITATION CENTER		1	8111 TISWELL DRIVE		
					ALEXANDRIA, VA 22306	***	
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•		le of 18 residents, to develop a	Γ΄ Δ	11 €	y		
		ne Facility staff failed to ral Care Plan for safety while in					
	The Findings include	led:					
	to the facility on 10/8 included History of E Cerebrum, Elbow Co	54 year old who was admitted /8/89. Resident #7's diagnoses Brain Injury, Hemorrhage of Contracture, Muscle miplegia (1 sided weakness).					
	Assessment with an of 11/18/15, coded F Severely Impaired C	Set, which was an Annual n Assessment Reference Date Resident #7 as having Cognition, and as requiring the se of 2 persons for transfers.					
	conducted. Resident in his bed, which was both full side rails up	P.M. a tour of the facility was not #7 was observed to be lying as in its lowest position, with p. In addition, he had a scoop ats on the floor on both sides					
	#7's clinical record, r physician's order, "2/ unable to define para	was conducted of Resident revealing the following signed 2/1/16. 2 side rails on bed -rameters of bed. Check safety s when in use. Start date			REC	ElVEl	300

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

10/10/13."

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

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

1		& MEDICAID SERVICES	Non-the-statement of the species of		OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495211	B. WING		02/03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MOUNT	VERNON NURSING A	ND REHABILITATION CENTER		8111 TISWELL DRIVE ALEXANDRIA, VA 22306	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFE DEFICIENCY)	DBE COMPLETION
F 279	Continued From pa	ge 5	F 2	79	

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

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495211	B. WING_		02/02/2046
	PROVIDER OR SUPPLIER VERNON NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 8111 TISWELL DRIVE ALEXANDRIA, VA 22306	02/03/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE COMPLETION E APPROPRIATE DATE
	to implementing the Resident #7's Care did not address his rails. The Care Plar for safety as related causing impaired sa involuntary movemed on 2/2/16 at 4:30 P. (Administration A), a (Administration B) w On 2/3/16 at 10:00 A stated that the side of the bed, which was subservation by the service which was a 483.25(h) FREE OF HAZARDS/SUPERV. The facility must ensenvironment remains as is possible; and e	Plan was reviewed. The plan behaviors and need for side a read, "Use of full side rails to Traumatic Brain Injury afety awareness and ent of extremities 11/29/15." M. the facility Administrator and Director of Nurses were informed of the findings. A.M. the facility Administrator rails had been removed from subsequently confirmed by an urveyor. ACCIDENT	F 27		new task on POC for 1:1
	by: Based on observation Based on observation record review, and fathe facility staff failed while toileting (Resident	T is not met as evidenced on, staff interview, clinical scility documentation review, to supervise one Resident ent #15) in the survey ts, and failed to ensure the locked.		5.In order to assure on going conduct a random audit weekly months.6. All findings will be submite rcommendations.7. The corrective action will be	x 4 weeks and monthly x 4 and to QAA for review and

1. For Resident #15, after experiencing multiple





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<u>OR MEDICARE</u>	£ & MEDICAID SERVICES			OMB NO. 0938-039
EFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED
	495211	B. WING		02/03/2016
DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 8111 TISWELL DRIVE ALEXANDRIA, VA 22306	
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rious falls due to mpting to walk us the bathroom of the sesident fell on out to the emericad. The second floodocked. It was docked. It was docked, blood collections were structed during the eallegations in the of the facility of the fac	to the Resident rising and unassisted to the bathroom, or back to bed, the facility staff the resident while toileting, and a 2/17/15 at 2:30 PM and was ergency room with bruises to or treatment room door was observed propped open. ection needles and stored in the room. ed: as added to the survey sample int investigation that was ne course of the survey. One of the complaint was regarding to assess and monitor a dinitially admitted to the facility dimitted on 3-6-14. Diagnoses obstruction and retention, ession, atrial fibrillation, alls, and stroke (CVA).	F 3	 No residents were affected All residents have the pote Immediate corrective action The plastic treatment cart 	ential to be affected. n was taken. was removed from the re placed on all medication s. on potential hazards and nce. complaince the facility will y x 4 weekly and monthly x 4 and to QAA for review and
CHES TO IN THE REPORT OF THE COMMENT SERVICES OF THE SERVICES	DER OR SUPPLIER JON NURSING A SUMMARY STA (EACH DEFICIENCY REGULATORY OR L tinued From partious falls due to mpting to walk to the bathroom d to supervise to Resident fell on out to the emerical cocked. It was cooked. It was cooked. It was cooked. It was cooked. It was cooked and to a complain to the facility dent. John Hamilton	A95211 DER OR SUPPLIER JON NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) tinued From page 7 rious falls due to the Resident rising and mpting to walk unassisted to the bathroom, or a the bathroom back to bed, the facility staff d to supervise the resident while toileting, and Resident fell on 2/17/15 at 2:30 PM and was out to the emergency room with bruises to nead. The second floor treatment room door was pocked. It was observed propped open. Sets, blood collection needles and ideations were stored in the room. findings included: Pesident #15 was added to the survey sample and of a complaint investigation that was ucted during the course of the survey. One a allegations in the complaint was regarding the of the facility to assess and monitor a	ABDICARE & MEDICAID SERVICES EFICIENCIES RRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495211 B. WING DER OR SUPPLIER ION NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The Design of the bathroom, or a the bathroom back to bed, the facility staff of to supervise the resident while toileting, and Resident fell on 2/17/15 at 2:30 PM and was out to the emergency room with bruises to need. The second floor treatment room door was pocked. It was observed propped open. Details, blood collection needles and idications were stored in the room. Indings included: Desident #15 was added to the survey sample and the facility to assess and monitor a dent. Indicated during the course of the survey. One allegations in the complaint was regarding to the facility to assess and monitor a dent. Indicated #15, was initially admitted to the facility 6-13, and readmitted on 3-6-14. Diagnoses ded; Urinary obstruction and retention, refersion, depression, atrial fibrillation, the sets, arthritis, falls, and stroke (CVA). Indent #15's most recent MDS (minimum data with an ARD (assessment reference date) of 15, was coded as a quarterly assessment. Ident #15 was coded as a dent #15 was coded as a life to make own life decisions. Resident #15 was coded as	OR MEDICARE & MEDICAID SERVICES EFFICIENCIES EFFICIENCIES REPCIENCIES EFFICIENCIES (X1) PROVIDERSUPPLERICULA DENTIFICATION NUMBER: 495211 B WING SUMMARY STATEMENT OF DEFICIENCIES ABILIT TISWELL DRIVE ALEXANDRIA, VA 22306 PROVIDERS PLAN OF CORE (EACH CORRECTIVE ACTION) CROSS REFERENCED TO THE A DEFICIENCY) 1. No residents were affected 2. All residents were affected 2. All residents have the pote 3. Immediate corrective action 4. The plastic treatment can't treatment room doors socked. It was observed propped open cets, blood collection needles and cations were stored in the room. findings included: seldent #15 was added to the survey sample and featons were stored in the room. 6. In order to assure ongoing conduct a random audit weekly, months. 7. All findings will be submitte recommendations. 8. The corrective action will be seldent #15, was initially admitted to the facility 6-13, and readmitted on 3-6-14. Diagnoses ded, Urinary obstruction and retention, retension, depression, atrial fibrillation, retension, and the course of the action

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



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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495211	B. WING			02/03/2016
	PROVIDER OR SUPPLIER VERNON NURSING A	ND REHABILITATION CENTER		811	REET ADDRESS, CITY, STATE, ZIP CODE I1 TISWELL DRIVE EXANDRIA, VA 22306	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	DBE COMPLETION
F 323	recent readmission 6-18-14, 6-30-14, 1 occurred on 2-17-1 Resident #15 was a was found that the so was not able to be resident #15's care included under the at risk for falls relating impairment, general decreased mobility. "Interventions" listeresident unattended 6-18-14. The care (doctor), and RP (Richanges." initiated of Review of Resident entries in the nurse following entries: On 2-16-15, the day that the Resident had given orange juice that an drug resistant based been placed in infection, which mestarted on an antibie these predisposing	erous falls, after the most , occurring on 5-25-14, 2-23-14. The most recent fall 5, after the MDS completion. a closed record review, and it resident expired on 4-11-15, be observed. e plan was reviewed and heading of "Focus", "Resident ed to confusion, visual lized weakness, and " Under the heading of d " "CNA's not to leave d when toileting." Initiated plan also included "Notify MD responsible Party) of any	F3	323		
	·	., Neurological checks had er the Resident was observed				

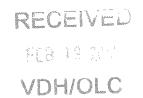
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lying on the floor outside the resident's bathroom. "CNA (certified nursing assistant) had placed

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Facility ID: VA0168

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495211	(X2) MULT A. BUILDIN B. WING		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLI			STREET ADDRESS, CITY, STATE, ZIP CODE 8111 TISWELL DRIVE	02/03/2016
WOOM VERMON NORON	SAND KENADILITATION CENTER		ALEXANDRIA, VA 22306	
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323 Continued From page 9

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

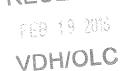
F 323

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RSMQ11

Facility ID: VA0168

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495211	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	
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F 323 Continued From page 10

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

F 323

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F 323	was a cart made of included a plastic ar The arm was propp door frame so that took. No residents immediate area. The treatment room items: Blood collection need boxes (48 count), or Lancets: 1 box, on a Biohazard refrigerat specimen and 1 fect Voltaren gel (for pai Hysept solution (solfull bottles Hydrogel (used to knounce tube) At 9:02 a.m., the Dirasked if the door was open. She stated not in use because in DON was shown the stated that the medicart. She checked to stated that the medicar who had been disch	white, plastic pipe. The cart rm that moved on a hinge. The determinant the door and the steed between the door and the steed between the door and the steed considered in the door would not close or were observed in the door were observed in the door were observed in the door were observed in the contained the following dedles (BD vacutainer brand): 7 in counters/ in drawers open shelf for: contained 1 blood all specimen n)- full tube door would be door would	F 3	23			
		ON asked the Assistant (ADON) about the cart and					

the medications. The ADON stated that the medications that were in the cart needed to be

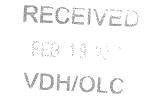
discarded. When asked how often the medications should be discarded, the ADON stated every month or every other month.



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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE
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F 323	Continued From pa	ge 12	F 32	3	
	biohazard refrigerat samples had been p morning. She thoug staff who had put th had propped the do No unlocked or prop	oped doors were observed at			
	any other time durin	g the survey.			
		nd DON were notified of the ed door at the end of day			
	COMPLAINT DEFIC 483.35(i) FOOD PR STORE/PREPARE/S	OCURE,	F 37	1 1.No Residents or Patients	had adverse effects.
	The facility must - (1) Procure food from	n sources approved or		All residents receiving co have the potential to be affe	
	authorities; and	ory by Federal, State or local istribute and serve food tions		3. The facility will provide ed personnel on proper usage how to properly cover all fac	of hair restraints and
				4.To assure on going compl will conduct daily audits on	laince the facility all dietary personnel.
	by: Based on observation	Γ is not met as evidenced on, and staff interview the prepare and serve food in a		5. In order to assure ongoin will conduct random audits of kitchen weekly x 4 and then	of personnel in the

The facility staff failed to effectively wear hair restraints while preparing and serving food.



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

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		495211	B. WING		02/03/2016
NAME OF PROV	IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	era
MOUNT VEDI	NON NURSING A	ND REHABILITATION CENTER		8111 TISWELL DRIVE	
WOONT VERI	NON NORSING A	ND REHABILITATION CENTER		ALEXANDRIA, VA 22306	
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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 431 483.60(b), (d), (e) DRUG RECORDS, SS=E LABEL/STORE DRUGS & BIOLOGICALS F 371 6. All findings will be submitted to QAA for review and recommendations.

DEFICIENCY)

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

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		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: 02/11/2016 FORM APPROVED MB NO. 0938-0391
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		495211	B. WING			02/03/2016
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F 431	Continued From pa	ge 14	F 4	131	No residents were affected.	
	a licensed pharmacof records of receip controlled drugs in accurate reconciliar records are in orde controlled drugs is reconciled. Drugs and biological labeled in accordar professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartment controls, and permit have access to the	State and Federal laws, the all drugs and biologicals in the note only authorized personnel to			 All residents have the potential to be Immediate corrective acation was taked. The faicility will institute a new processhift RN supervisor will audit medication boxes nighlty for expiration dates. The staff will be educated on the new In order to assure on going complain conduct a random audit weekly x 4 weemonths. All findings will be submitted to QAA recommendations. The corrective action will be completed. 	ken. ss, where the night n refrigerators and IV w process. see the facility will eks and monthly x 4 for review and

This REQUIREMENT is not met as evidenced

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

Based on observation, staff interview, facility documentation review and clinical record review,

Facility ID: VA0168

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be readily detected.

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		495211	B. WING			02	2/03/2016
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F 431	Continued From pa	nge 15	F	131			
	medication rooms (ed to ensure that one of two Second Floor medication expired medications and					
	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:						
	Medication Room of conducted with Ever Registered Nurse Ontravenous Solution (intravenous) box: 1000 milliliter bag of Expiration Date Aug	of Sodium Chloride expiration					
		f Flu vaccine was observed in virin multidose vial Expiration					
	conducted with RN stated "the facility of vaccines this year. hight should be checking the medic C stated the "Pharm IV solutions and materials for the facility." RN	5 PM, an interview was C (Registered Nurse C) who ordered single dose Flu Separate syringes were used ift nurses are responsible for eations in the refrigerator. RN macy is in charge of checking aking sure they are available C also stated the "IV box was a (2/2/2016) with the expired IV					

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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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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
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F 431	refrigerator and the removed from the I on 2/2/2016 during approximately 4:15 (DON), Administrat Nursing were informedications and IV medication room, she had been inforsupervisor and was were expired since box. The DON states the Pharmacy should fall medications at the facility and nur expiration dates primedications or IV fill.	IV fluids. ation was removed from the expired IV fluids were V box. If the end of day debriefing at PM, the Director of Nursing for and Assistant Director of med of the findings of expired I fluids in the second floor. The Director of Nursing stated med by the evening shift is surprised that the IV fluids Pharmacy just delivered the ted the expectation was that all check the expiration dates and IV fluid prior to delivering to see should check the or to administering fluids.	F 43		
F 441 SS=F	information regardi	I not present any further ng the findings. I CONTROL, PREVENT	F 44 ⁻	 1. Resident # 4 had no adverse action was taken. 	effects. Immediate
	Infection Control Pr safe, sanitary and of to help prevent the of disease and infe (a) Infection Control The facility must es Program under whi	ol Program Stablish an Infection Control		 2. All residents receiving care har affected. 3. The facility will institute a new a. There will be an isolation to CNA's when a resident is of the isolation care plans with of isolations and this will be kardex. 	v infection control policy. ask added to POC to alert on islolation. ill be updated to reflect type

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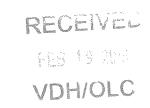
(2) Decides what procedures, such as isolation,

in the facility;

Event ID: RSMQ11

Facility ID: VA0168

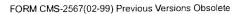
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4. The staff will be educated on the new process.

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o an individual resident; and ord of incidents and corrective affections. ead of Infection tion Control Program esident needs isolation to of infection, the facility must to prohibit employees with a ease or infected skin lesions with residents or their food, if transmit the disease. It require staff to wash their frect resident contact for which dicated by accepted ease. Indie, store, process and as to prevent the spread of the staff interview, resident to the facility and the facility staff foiled to the staff interview and the facility staff foiled to the	F 441	 5. In order to assure on going coconduct a random audit weekly months. 6. All findings will be submitted trecommendations. 7. The corrective action will be commendations. 	x 4 weeks and monthly x 4 o QAA for review and
	A95211 IND REHABILITATION CENTER TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) To an individual resident; and ord of incidents and corrective effections. The analysis of the facility must of infection, the facility must of infection, the facility must of infection, the facility must of infection and infection and infection and infection and infection and infection	**MEDICAID SERVICES **(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **495211 **ND REHABILITATION CENTER** **ND REHABILITATION CENTER** **TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) **GREEN TO THE PROCEST OF THE PRECEDED BY FULL SCIDENTIFYING INFORMATION) **GREEN TO THE PRECEDED BY FULL SCIDENTIFYING INFORMATION) **FA41 **GREEN TO THE PRECEDED BY FULL SCIDENTIFY INFORMATION INF	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495211 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CO

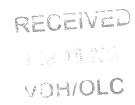


For Resident #4, the CNA did not wear gloves, or properly apply a gown while providing care to Resident #4, who was under Isolation Contact precautions for an active Clostridium Difficile



Facility ID: VA0168





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F 441	Continued From pa	ige 18	F	141			
	(C-Diff) communica	able infection. The facility did					
	track infections, ho	wever, the facility had no y initiatives, and also failed to					
	have an effective in	nfection control program to					
	include policies and	d procedures to help prevent					
	the development all infection.	nd transmission of disease and					
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	http://www.cdc.gov erpt.html	/HAI/organisms/cdiff/Cdiff_exc					
	the organism can be health-care worker handwashing rema	erium" causing diarrhea and be spread to others by hands of s; wearing gloves and proper ains the most effective means nination. Please refer to the					
	The findings include	led;					
	1-30-16. Diagnose infection placed in precautions for coladmission to the fall Neutropenia, hype	admitted to the facility on es included C-Diff enterocolitis isolation and on contact mmunicable disease upon acility, Lung cancer, rtension, high cholesterol, on, and (COPD) chronic mary disease.					
	set) was an admis	st recent MDS (minimum data sion assessment and had not s the Resident had only been s at the time of survey.					

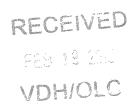
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On 2-2-16 at 9:00 AM, the Resident was observed in bed receiving care from certified

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 441 Continued From page 19

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,

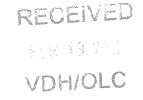
F 441

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Facility ID: VA0168

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	The Collection of the Collecti	(X3) DATE SURVEY COMPLETED
	495211	B. WING		02/03/2016
NAME OF PROVIDER OR SUPPLIES MOUNT VERNON NURSING	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8111 TISWELL DRIVE ALEXANDRIA, VA 22306	
PREEIX (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION

F 441 Continued From page 20

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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If continuation sheet Page 21 of 26

VDH/OLC

F 441

PRINTED: 02/11/2016

		& MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-03!
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		495211	B. WING	; 	02/03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE
MOUNT	VERNON NURSING A	ND REHABILITATION CENTER		8111 TISWELL DRIVE ALEXANDRIA, VA 22306	
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F 441	Assurance or improplanned as a result Registered Nurse (I policies we have. Founseled the CNA infection control brefor credible evidence he stated he didn't hat they institute che with infection control examples of change quality assurance phe was asked how infection control proconducting rounds a practices. RN D states.	owever, no trending or Quality vement initiatives had been	F	441	

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

unaware of the correct isolation protocols for contact precautions, and the facility was not conducting rounds to identify lapses in the staff

On 2-3-16 at the end of the day exit, the

provided.

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

infection control practices.

The facility must ensure that nurse aides are able

F 498 1. No residents were affected.

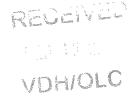
- 2. All residents receiving care have the potential to be affected
- 3. Immediate corrective action was taken.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RSMQ11

Facility ID: VA0168

If continuation sheet Page 22 of 26



PRINTED: 02/11/2016 FORM APPROVED

CENTERS FOR MEDICARE	E & MEDICAID SERVICES			<u>OMB NO. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	B. WING		02/03/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MOUNT VERNON NURSING A	AND REHABILITATION CENTER		8111 TISWELL DRIVE ALEXANDRIA, VA 22306	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		LD BE COMPLETION
F 498 Continued From pa	age 22	F۷	198 4. The facility will institute a new proc	cess which will begin on

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 CNAB, and

- 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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	n LL Contonio	(X3) DATE SURVEY COMPLETED
	495211	B. WING		02/03/2016
NAME OF PROVIDER OR SUI	PPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
			8111 TISWELL DRIVE	
MOUNT VERNON NURS	SING AND REHABILITATION CENTER		ALEXANDRIA, VA 22306	
PREEIX (EACH DEF	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION

F 498 Continued From page 23

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

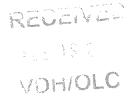
F 498

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RSMQ11

Facility ID: VA0168

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

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

CENTE	OMB NO. 0938-0391					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495211	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	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	X (EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 498	8 Continued From page 24 rails of the bed when she put them up, and the bed linens without gloves. The DON stated she told CNAB 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.		F 4	.98		

1. Isolation Policy (mentioned above)

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;

- 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

2567/02-00) Previous Versions Obsolete Event ID: RS

Facility ID: VA0168

If continuation sheet Page 25 of 26



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

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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
	495211	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					
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F 498 Continued From page 25

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.

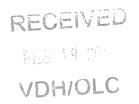
F 498

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RSMQ11

Facility ID: VA0168

If continuation sheet Page 26 of 26





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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COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

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

Marissa J. Levine, MD, MPH, FAAFP

State Health Commissioner

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.



Mr. Robert Demaria, February 11, 2016 Page 2

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/".

Mr. Robert Demaria, February 11, 2016 Page 3

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.

Mr. Robert Demaria, February 11, 2016 Page 4

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, LTC Supervisor

Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman

Jaime Desper, D M A S (Sent Electronically)