| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | VA0177 | A. BUILDING _____ B. WING _____ | 10/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MANORCARE HEALTH SERVICES-ALEXANDRIA | 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| F 000 | Initial Comments<br><br>An unannounced biennial State Licensure Inspection was conducted 10/08/19 through 10/10/19. Two complaints were investigated. Corrections are required with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.<br><br>The census in this 96 certified bed facility was 81 at the time of the survey. The survey sample consisted of 35 current Resident reviews and four closed record reviews. | F 000 | | |
| F 001 | Non Compliance<br><br>The facility was out of compliance with the following state licensure requirements:<br><br>This RULE: is not met as evidenced by:<br>12 VAC 5 - 371 - 140 E 3<br><br>Based on staff interview, facility document review and employee record review, it was determined the facility staff failed to screen employees, per their policy, prior to hire for five of 20 employee records reviewed, CNA (certified nursing assistant) # 5, CNA #6, CNA #7, CNA #8 and LPN (licensed practical nurse) #6.<br><br>A. The facility staff failed to obtain a sworn statement for one of 20 employee records reviewed, CNA #6.<br>B. The facility staff failed to verify a license for one of 20 employee records reviewed, CNA #7.<br>C. The facility staff failed to perform reference checks for four of 20 employee records reviewed, CNA #5, CNA #7, CNA #8 and LPN #6.<br><br>The findings include: | F 001 | F 001<br><br>The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.<br><br>I. Corrective Action<br><br>The process was immediately started to obtain a sworn statement from CNA #6 and reference checks for CNA's #5, CNA #7, CNA #8 and LPN #6. The process was immediately started to locate the original license verification for CNA #7. Audit started on all other employee records for compliance.<br><br>II. Identification<br><br>All residents in the facility have the potential to be affected by failing to follow the policy of Patent Protection: Abuse, Neglect, Exploitation, Mistreatment & Misappropriation Prevention. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

LNHA — ADMINISTRATOR — 11-1-19

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| F 001 | Continued From Page 1<br><br>A. The facility staff failed to obtain a sworn statement for one of 20 employee records reviewed.<br><br>The review of the personnel file of CNA #6 failed to evidence a sworn statement signed by CNA #6 upon hire on 10/4/18.<br><br>On 10/10/19 at 2:47 p.m., the file for CNA #6 was reviewed with ASM (administrative staff member) #1, the administrator, and OSM (other staff member) #8, the human resources staff member.<br><br>On 10/10/19 at 4:10 p.m., ASM #8 returned and stated she could not find the sworn statement for CNA #6.<br><br>B. The facility staff failed to verify a licensed for one of 20 employee records reviewed, CNA #7.<br><br>The review of the personnel file of CNA #7 failed to evidence a license verification was obtained prior to hire. CNA #7's hire date of 1/30/18.<br><br>On 10/10/19 at 2:47 p.m., the file for CNA #7 was reviewed with ASM (administrative staff member) #1, the administrator, and OSM (other staff member) #8, the human resources staff member.<br><br>On 10/10/19 at 4:10 p.m., ASM #8 returned and stated she could not find the license verification at the time of hire for CNA #7.<br><br>C. The facility staff failed to perform reference checks for four of 20 employee records reviewed, CNA #5, CNA #7, CNA #8 and LPN #6.<br><br>The personnel files of CNA #5, CNA #7, CNA #8 and LPN #6 were reviewed. The files failed to evidence the documentation of references being performed prior to hire dates of CNA #5 - 10/5/17, | F 001 | III. Systematic Changes<br><br>Human Resources Director will be educated by the Senior Regional Human Resource's Manager on the facilities employee screening policy.<br><br>I.V Monitoring<br><br>Human Resources Director and/ or designee will audit staff records to ensure required screenings and background checks are completed per facility policy- 5 random records daily x five, weekly x four and then monthly x two. These audits will be sent to the Quality Assurance Assessment Committe to determine if further audits or actions or needed.<br><br>V. Date of Completion<br><br>11/24/19 | |

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| F 001 | Continued From Page 2<br><br>CNA #7 - 1/30/18, CNA #8 - 8/2/19, and LPN #6 - 2/13/19.<br><br>On 10/10/19 at 2:47 p.m. the files for CNA #5, CNA #7, CNA #8 and LPN #6 were reviewed with ASM (administrative staff member) #1, the administrator, and OSM (other staff member) #8, the human resources staff member.<br><br>On 10/10/19 at 4:10 p.m., ASM #8 returned and stated she could not find the references at the time of hire for CNA #5, CNA #7, CNA #8 and LPN #6.<br><br>The facility policy, "Patient Protection: Abuse, Neglect, Exploitation, Mistreatment & Misappropriation Prevention" documented in part, "Employee Screening: The center screens prospective employees to reduce the risk that no one is hired who is likely to abuse patients. The center utilizes the employee screening process to identify information from: Previous employers and current employers, with applicant permission, state licensing boards and registries; for nursing assistants, every state registry that is believed to have information on the potential employee and criminal background checks."<br><br>ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant, were made aware of the above findings on 10/10/19 at 4:20 p.m.<br><br>No further information was provided prior to exit.<br><br>CROSS REFERENCES<br><br>12 VAC 5 - 371 - 140 A - cross references to Federal Deficiency - 607<br><br>12 VAC 5 - 371 - 140 E 3 - cross references to | F 001 | | |

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| F 001 | Continued From Page 3<br><br>Federal Deficinecy - 609<br><br>12VAC5-371-140. Policies and procedures.<br><br>Virginia Nursing Home Regulation 12VAC5-371-140 states "B. All policies and procedures shall be reviewed at least annually, with recommended changes submitted to the governing body for approval."<br><br>On 10/10/19 at approximately 4:30 p.m., the facility's policy and procedure manuals were reviewed. Review of the facility's policy and procedure manuals for "Administrative", "Medical Director/physician services", "Contract Services", "Resident Rights/grievances" and "Facility Security" did not evidence an annual review sheet.<br><br>On 10/10/19 at approximately 4:30 p.m. and interview was conducted with the ASM [administrative staff member] # 1, administrator regarding the policy and procedure manual for "Administrative", "Medical Director/physician services", "Contract Services", Resident Rights/grievances" and "Facility Security." ASM # 1 stated he did not realize all facility policy's required annual review.<br><br>No further information was provided by the end of the survey. | F 001 | F 001<br><br>The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.<br><br>I. Corrective Action<br><br>The Administrator was immediately educated by the Quality Consultant on the regulation that all facility policies and procedures shall be reviewed at least annually with recommended changes submitted to the Quality Assurance and Assessment Committee<br><br>II. Identification<br><br>All residents in the facility have the potential to be affected by the alleged practice.<br><br>III. Systematic Changes<br><br>Administrator and/or designee will re-educate department managers that all facility policies and procedures shall be reviewed at least annually with recommended changes submitted to the Quality Assurance and Assessment Committee.<br><br>I.V Monitoring<br><br>Administrator and/ or designee will audit facility policies and procedures to assure at least an annual review was completed with evidence of an annual review sheet sign-off. The audit will include 5 random policies/procedures daily x five, weekly x four and then monthly x two. These audits will be sent to the Quality Assurance Assessment Committe to determine if further audits or actions or needed.<br><br>V. Date of Completion<br><br>11/24/19 | |