| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A COVID-19 Focused Emergency Preparedness Survey was conducted 1-26-2021 through 1-28-2021. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19.<br><br>The census in this 130 certified bed facility was 81 at the time of the survey. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A COVID-19 Focused Infection Control survey and Abbreviated (complaint) survey was conducted 1-26-2021 through 1-28-2021. The facility was in substantial compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19.<br><br>However, Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The survey sample consisted of 4 residents.<br><br>The census in this 130 certified bed facility was 81 at the time of the survey. | F 000 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, | F 658 | | 2/22/21 |

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

Electronically Signed | 02/19/2021

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 658 | Continued From page 1<br>must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide care and services according to professional standards for one resident (Resident #2) in a sample size of 4 residents.<br><br>For Resident #2, the facility staff failed to enter physician's orders into the electronic health record timely for foam dressing changes resulting in a delay in treatment. Also, the facility staff failed to enter physician's orders into the electronic health record for the pressure-relieving treatment as ordered by the physician on 03/20/2019.<br><br>The findings include:<br><br>Resident #2, a 76-year old male, was admitted to the facility on 03/17/2019 and discharged on 04/08/2019. Diagnoses included but were not limited to cellulitis of left lower limb and stage 3 pressure ulcer of left heel.<br><br>Resident #2's Minimum Data Set with an Assessment Reference Date of 03/24/2019 was coded as an admission assessment. The Brief Interview for Mental Status was coded as "13" out of possible "15" indicative of intact cognition. Functional status for bed mobility was coded as requiring extensive assistance from staff with 2+ persons physical assistance for support. Stage 3 Pressure Ulcers were coded as "1" meaning one. Number of Venous and Arterial Ulcers were coded as "3" meaning three. | F 658 | 1. Identified resident no longer resides at facility, discharged to home in April 2019.<br>2. 100% audit conducted on all current residents' treatment orders for dressings and pressure-relieving treatments to:<br>• Identify any residents that have the potential to be affected by alleged deficient practice.<br>• Ensure all residents admitted with pressure injuries have appropriate preventive devices in place.<br>• Ensure all physician-prescribed treatment regimens are being administered consistent with the current order for that resident.<br>100% audit conducted on all current residents' care plans to ensure all current, physician-prescribed treatment regimens are reflected in the care plan.<br>100% audit conducted on all current residents' kardexes to ensure staff are aware of all current, physician-prescribed treatment regimens.<br>3. Director of Nursing/Designee in-serviced all nursing staff on policies, procedures and protocols specific to physician-prescribed treatment regimens for residents.<br>4. Director of Nursing/Designee will conduct audits 2x/week for 2 months on current residents with pressure injury treatment orders, pressure relieving treatment orders, and TARs to ensure 100% compliance with physician-prescribed treatment regimens, | |

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 658 | Continued From page 2<br><br>On 01/26/2021, the closed clinical record was reviewed. The document dated 03/20/2019 entitled, "Specialty Physician Initial Wound Evaluation & Management Summary" was electronically signed by the physician on 03/20/2019. Under the header, "Focused Wound Exam (Site 1) Stage 3 Pressure Wound of the Left Heel" and sub-header, "Dressing Treatment Plan", it was documented, "Foam w/bdr [with border] apply every three days for 30 days." Under the sub-header, "Additional Wound Detail", it was documented, "Recommend prevalon boots." Under the header "Focused Wound Exam (Site 2) Arterial Wound of the Left Foot, Dorsal Foot" and sub header "Dressing Treatment Plan", it was documented, "Primary dressing: Alginate calcium w/silver [with silver] apply every three days for 30 days. Secondary dressing; Dry protective dressing apply every three days for 30 days." Under the header, "Focused Wound Exam (Site 3) Arterial Wound of the Left Leg" and sub header "Dressing Treatment<br>Plan", it was documented "Primary dressing: Xeroform sterile gauze apply every three days for 30 days. Secondary dressing: Dry protective dressing apply every three days for 30 days." Under the header, "Focused Wound Exam (Site 4) Arterial Wound of the Right Leg" and sub header "Dressing Treatment Plan", it was documented, "Xeroform sterile gauze apply every three days for 30 days."<br><br>A physician's order dated 03/27/2019 documented "Foam dressing to left heel every day shift every three days for left heel pressure wound. Cleanse wound with wound cleanser, pat dry, apply foam dressing as ordered." A physician's order dated 03/27/2019 documented | F 658 | with timely education and coaching to direct-care staff as warranted. Results of these audits will be presented at both the weekly Risk Management and monthly QAPI Committee meetings x3 months for their review and recommendations. | |

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 658 | Continued From page 3 | F 658 | | |

"Left dorsal foot every day shift every three days for arterial wound. Cleanse wound with wound cleanser, pat dry, apply alginate calcium with silver, and cover with dry protective dressing." A physician's order dated 03/27/2019 documented, "Left leg wound every day shift every three days for arterial wound. Cleanse wound with wound cleanser, pat dry, apply Xeroform sterile gauze and cover with dry protective dressing." A physician's order dated 03/27/2019 documented, "Right leg wound every day shift every three days for arterial wound. Cleanse wound with wound cleanser, pat dry, apply Xeroform sterile gauze and cover with dry protective dressing." These orders were entered into the electronic health record 7 days after they were ordered by the wound physician. In addition, no order for prevalon boots was entered.

On 01/26/2021 at approximately 4:55 P.M., an interview with the Assistant Director of Nursing (ADON) was conducted. When asked about the process for order management by the wound physician, the ADON stated that the wound nurse would make rounds with the wound physician and the wound nurse would enter the wound physician orders into the electronic health record. When asked about the expectation of timeliness, the ADON stated she would expect the orders to be entered into the electronic health record the same day the wound physician ordered them.

On 01/27/2021, the facility staff verified their professional standard resource is Potter & Perry. According to an Elsevier (Mosby) publication, Fundamentals of Nursing by Potter & Perry, 2013, in Chapter 18 entitled, "Planning Nursing Care" on p. 237 it was documented, "Priority setting begins at a holistic level when you identify and

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 658 | Continued From page 4<br>prioritize a patient's main diagnoses or problems. However, you also need to prioritize the specific interventions or strategies that you will use to help a patient achieve desired goals and outcomes."<br><br>In summary, the wound physician ordered dressing treatments for wounds and prevalon boots on 03/20/2019. The orders were entered into the electronic health record 7 days after they were ordered resulting in a delay in treatment. The prevalon boots were not entered into the electronic health record for the duration of Resident #2's stay at the facility.<br><br>On 01/26/2021 at approximately 5:30 P.M., the administrator and Director of Nursing were notified of findings. | F 658 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, clinical record review, facility documentation review, and in the course | F 686 | 1. Identified resident no longer resides at facility, discharged to home in April 2019. | 2/22/21 |

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 686 | Continued From page 5<br>of a complaint investigation, the facility staff failed to provide a pressure-relieving treatment and dressing as ordered by a physician on 03/20/2019. For Resident #2, the facility staff failed to provide prevalon boots and timely foam dressing treatments as ordered by the physician on 03/20/2019.<br><br>The findings include:<br><br>Resident #2, a 76-year old male, was admitted to the facility on 03/17/2019 and discharged on 04/08/2019. Diagnoses included but were not limited to cellulitis of left lower limb and stage 3 pressure ulcer of left heel.<br><br>Resident #2's Minimum Data Set with an Assessment Reference Date of 03/24/2019 was coded as an admission assessment. The Brief Interview for Mental Status was coded as "13" out of possible "15" indicative of intact cognition. Functional status for bed mobility was coded as requiring extensive assistance from staff with 2+ persons physical assistance for support. Stage 3 Pressure Ulcers were coded as "1" meaning one. Number of Venous and Arterial Ulcers were coded as "3" meaning three.<br><br>On 01/26/2021, the closed clinical record was reviewed.<br><br>A physician's order dated 03/19/2019 documented, "Petroleum gauze to wound to left and right lower legs, left foot and heel, cover with cling QD [every day] and PRN [as needed] until seen by wound MD [medical doctor] every day shift for wound care."<br><br>The document dated 03/20/2019 entitled, | F 686 | 2. 100% audit conducted on all current residents□ treatment orders for dressings and pressure-relieving treatments to:<br>" Identify any residents that have the potential to be affected by alleged deficient practice.<br>" Ensure all residents admitted with pressure injuries have appropriate preventive devices in place.<br>" Ensure all physician-prescribed treatment regimens are being administered consistent with the current order for that resident.<br>100% audit conducted on all current residents□ care plans to ensure all current, physician-prescribed treatment regimens are reflected in the care plan.<br>100% audit conducted on all current residents□ kardexes to ensure staff are aware of all current, physician-prescribed treatment regimens.<br>3. Director of Nursing/Designee in-serviced all nursing staff on policies, procedures and protocols specific to physician-prescribed treatment regimens for residents.<br>4. Director of Nursing/Designee will conduct audits 2x/week for 2 months on current residents with pressure injury treatment orders, pressure relieving treatment orders, and TARs to ensure 100% compliance with physician-prescribed treatment regimens, with timely education and coaching to direct-care staff as warranted. Results of these audits will be presented at both the weekly Risk Management and monthly QAPI Committee meetings x3 months for their review and recommendations. | |

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 686 | Continued From page 6 | F 686 | | |

"Specialty Physician Initial Wound Evaluation & Management Summary" was electronically signed by the physician on 03/20/2019. Under the header, "Focused Wound Exam (Site 1) Stage 3 Pressure Wound of the Left Heel" and sub-header, "Dressing Treatment Plan", it was documented, "Foam w/bdr [with border] apply every three days for 30 days." Under the sub-header, "Additional Wound Detail", it was documented, "Recommend prevalon boots."

A physician's order dated 03/27/2019 documented "Foam dressing to left heel every day shift every three days for left heel pressure wound. Cleanse wound with wound cleanser, pat dry, apply foam dressing as ordered." This order were entered into the electronic health record 7 days after it was ordered by the wound physician. There was no order for prevalon boots.

The Treatment Administration Record for March 2019 was reviewed. A treatment entitled "Foam dressing to left heel every day shift every three days for left heel pressure wound. Cleanse wound with wound cleanser, pat dry, apply foam dressing as ordered" was initially signed off as administered on 03/28/2019 which was 8 days after it was ordered by the wound physician. There was no treatment administration addressing prevalon boots.

On 01/26/2021 at approximately 4:55 P.M., an interview with the Assistant Director of Nursing (ADON) was conducted. When asked about the process for order management by the wound physician, the ADON stated that the wound nurse would make rounds with the wound physician and the wound nurse would enter the wound physician orders into the electronic health record.

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 686 | Continued From page 7<br><br>The facility staff provided a copy of their policy entitled, "Wound Care." Under the header "Policy", it was documented, "Residents/patients admitted with or develop skin integrity issues will receive treatment as indicated based on location, stage, and drainage." The policy did not address the process of receiving orders from the wound physician.<br><br>In summary, the facility staff failed to provide pressure-reducing prevalon boots for an existing pressure injury as ordered by the physician on 03/20/2019. Also, the initial administration of the foam dressing to the left heel was dated 03/28/2019 which was 8 days after the wound physician ordered it.<br><br>On 01/26/2021 at approximately 5:30 P.M., the administrator and Director of Nursing were notified of findings. | F 686 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to mitigate a fall hazard | F 689 | 1. Identified resident no longer resides at facility, discharged to hospital on 1/21/20 and did not re-admit to facility.<br>2. 100% audit conducted on all: | 2/22/21 |

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 689 | Continued From page 8<br>resulting in harm for 1 resident (Resident #1) from a sample of 4 Residents.<br><br>The findings included:<br><br>Resident #1 fell twice on 12-21-2020. The second fall required an emergency room visit, and hospital admission after sustaining a head injury. The Resident first fell at approximately 3:00 p.m. on 12-21-2020, sustaining no injury, and was then placed back in bed unattended and fell again at approximately 4:30 p.m. sustaining a head injury with bleeding and swelling requiring an emergency room visit and hospital admission for subdural hematoma to the brain. The Resident also suffered an intraparenchymal hemorrhage, however, the Radiology report from the hospital revealed that the physician did not feel this was caused by the fall. The Resident expired on 12-27-2020 while hospitalized.<br><br>Resident #1 was admitted to the facility on 12-18-2020 at approximately 6:51 p.m. according to a nursing admission assessment. The Resident's 3 day MDS (minimum Data Set) assessment dated 12-21-2020 revealed that the Resident required extensive assistance, or was totally dependent for all activities of daily living with 2 staff member assistance. The Resident was always incontinent of bowel and bladder. The Resident was severely cognitively impaired and not able to complete a Brief Interview for mental status (BIMS) assessment. The MDS documented incorrectly at section J, that the Resident had no previous falls prior to entry, and had only one fall since entry to the facility, prior to discharge. The assessment was signed as complete and accurate on 1-1-2021. | F 689 | • Residents that have had falls since 1/26/2021, to:<br>• identify any residents that have the potential to be affected by the alleged deficient practice<br>• determine if established fall precautions and protocol were followed.<br>• Residents' fall risk assessments to identify residents at risk for falls.<br>• Residents' care plans to ensure appropriate interventions for falls were in place.<br>• Residents' kardex to ensure staff are aware of interventions.<br>3. Director of Nursing/Designee in-serviced all nursing staff on the following policies and procedures related to resident falls:<br>• Fall Risk Assessment<br>• Timely Interventions, RP notification and documentation following a resident fall following a fall<br>• Resident monitoring and documenting<br>• Availability and location of equipment and supplies (e.g., fall mats)<br>• Accurate and Complete Incident Reporting on RiskWatch<br>Regional Director of Clinical Services will educate Nursing Administration on conducting a complete and thorough investigation.<br>4. Director of Nursing/Designee will conduct daily audits of all residents' falls, with timely education and coaching to direct-care staff as warranted. Results of these audits will be presented at both the weekly Risk Management and monthly QAPI Committee meetings x3 months for their review and recommendations. | |

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 689 | Continued From page 9 | F 689 | | |

Hospital records received by the facility upon admission were reviewed. Those revealed that the Resident had fallen at home prior to admission to the hospital, and that the Resident was a fall risk and agitated while at the hospital requiring a companion sitter. While in the hospital an antianxiety medication was ordered prior to transfer and admission to the Nursing facility.

The 48 hour baseline care plan was reviewed and revealed that it was effective as of 6:51 p.m. on 12-18-2020, the day of admission, and was signed as completed by the interdisciplinary team on 12-19-2020. The care plan documented that the Resident was confused, had a history of falls, had no assistive devices, had bruising on both arms, bruising on right side of the fore head, and left knee. As "cognitive/psychosocial behavior concerns" the document listed "Resident trying to get out of bed". On the last page an undated handwritten note was added by the facility which documented "Focus Problem" "safety/fall precaution " staff to assist with mobility.", and "(Name of Resident) has had an actual fall." "Goal: monitor patient for any change. Intervention: (Resident name) was sent to the hospital for more evaluation." No fall precaution interventions were ever care planned during the facility stay for this Resident.

Physical (PT) therapy, Occupational (OT) therapy, and Speech (ST) therapy notes were reviewed and revealed the following:

Physical therapy notes revealed that on 12-19-2020 at 7:09 p.m., after the PT eval was completed the PT positioned the Resident back in bed and left the Resident's room. The PT went

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 689 | Continued From page 10 | F 689 | | |

back to the Resident's room and found the Resident "positioned with feet on the floor and head on the side of the bed." The PT then documented "Positioned patient back with head of bed and bilateral extremities elevated and lowered the bed (the bed had been in high position). Notified CNA (Certified Nursing Assistant) to be on watch due to risks for falls".

On 12-20-2020 at 12:51 p.m., the PT notes documented "Patient received sitting in hallway in geri chair (recliner)...CNA staff made aware of patient positioning and nursing cart was placed behind patient geri chair to prevent the chair from sliding backwards."

On 12-21-2020 at 2:01 p.m. the PT notes documented "Patient found different geri chair with working brakes and patient ended session seated in geri chair in hallway for increased supervision."

On 12-21-2020 at 2:05 p.m. the OT notes documented "Discussed with nursing staff patient's past medical history as well as safety concern due to severe dementia and restlessness." "Co-treat with PT due to safety concerns because of decreased ability to follow commands with patient being hard of hearing and having severe cognitive impairments at baseline to decrease risk for falls."

Nursing progress notes were reviewed for the Residents 3 day stay in the facility and revealed the following;

On 12-21-2020 at 3:27 p.m., the nursing note document read "Resident was found on the floor lying on (gender) right side. Head to toe

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 689 | Continued From page 11 | F 689 | | |

assessment done and Resident denies pain. No injuries noted. Resident was put back in bed and redirected."

On 12-21-2020 at 7:48 p.m. the nursing note document read "Resident sustained a fall and had a cut on the right upper side of his face and cut. Dr (name) was notified and Resident sent out to (name of hospital). RR (son of Resident name) notified."

On 12-21-2020 at 7:57 p.m., the nursing note document read "Physician notified at 5:00 p.m., Responsible party notified at 6:00 p.m.

The first "Fall Risk assessment" document in the clinical record was completed for this Resident on 12-21-2020 at 8:09 p.m. after the 2 falls had occurred. The form documented Resident #1 as "Diminished safety awareness, fall in the past 30 days, Resident is a fall risk."

The first "Fall Follow Up" document in the clinical record was completed on 12-21-2020 at 8:11 p.m. after the 2 falls had occurred. As for interventions to prevent another fall "redirect" was given as the only answer.

The facility doctor who was treating Resident #1 documented a History and Physical form dated 12-21-20 at 5:30 p.m., which read: "Patient alert but confused does not answer questions or follow commands." "Patient is not capable of making any decisions regarding (gender) care." Indicating that the Resident was severely demented and unable to follow direction or redirection.

A "Hospital Transfer Cover Sheet" was reviewed

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 689 | Continued From page 12 | F 689 | | |

and indicated the reason for the transfer to the hospital was for "Fall evaluation, sustained a hematoma the size of an egg on the right temporal area bleeding."

EMS notes were reviewed and revealed that on 12-21-2020 an ambulance was called for Resident #1 at 4:30 p.m., which arrived on scene at the facility at 4:38 p.m. The Resident was discharged into the care of Emergency Medical Services (EMS), who documented a 3 foot ground level fall as the reason for the transport to the hospital with injury. EMS delivered the Resident to the hospital at 4:58 p.m.

Resident #1's two falls are listed below:

1. A Nursing hand written and signed witness statement documented the following;

"On 12-21-2020 at 7:00 a.m., report was given to me by the outgoing nurse on (name of Resident #1) a (gender) new admit who is a fall risk due to confusion and agitation. Resident was witnessed in a Geri chair (recliner) for proper monitoring and safety. Resident had no sleep during the night. After taking report, Resident was seen restless and wanted to get out of Geri chair. (Resident name) later verbalized he wanted to sleep. The CNA (certified Nursing Assistant) and myself put (gender) in bed and therapy came for (gender) later. After Resident came back (from therapy) (gender) was witnessed finishing lunch. Later around 3:00 p.m. Resident seen on the floor. After head to toe assessment Resident was not noted with no injuries."

2. A Nursing hand written and signed witness statement documented the following;

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 689 | Continued From page 13 | F 689 | | |

"Later at 3:50 p.m., Resident was found on the floor again with a hematoma and a cut to the right upper forehead. Bed was in the lowest position and 911 was called immediately and Resident was taken to the emergency room. Son and MD (doctor) notified."

The facility Fall Protocol and policy were requested and supplied. Review of the facility documents revealed the following:

Policy "It is the policy of this facility to promote resident centered care by providing a fall risk observation on admission, quarterly and following any fall that occurs." Procedure: 1. Complete the fall risk observation found in the electronic medical records." 2. Institute appropriate precautions that are individualized to the resident needs."

In summation of findings, the Resident was known to be confused, agitated, unable to be redirected, and a known fall risk with a known history of falls with injury. No interventions were planned or specified to prevent falls, or mitigate serious injury. The first fall occurred while the Resident was unsupervised in bed on 12-21-2020. Staff did not intervene after the first fall and placed the Resident back in bed unattended. Resident #1 fell a second time on 12-21-2020 causing serious injury and requiring hospitalization.

On 1-27-2021 at the end of day meeting, Resident #1's falls were reviewed with the Administrator and Director of Nursing (DON). They were asked to provide investigations and statement by staff of the falls and precipitating

| 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 _____ | C 01/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNT VERNON HEALTHCARE 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 689 | Continued From page 14<br>and mitigating information. On 1-28-2021 at 12:00 p.m., during the end of day meeting the Administrator and DON were again made aware of the lack of supervision for Resident #1, and asked for any further information as the second fall resulted in harm for the Resident. On 1-28-2021 at 2:00 p.m. during the exit interview, the Administrator and Director of Nursing stated they had nothing else to provide. All information regarding the falls was accepted and reviewed. No further information was provided.<br><br>COMPLAINT DEFICIENCY | F 689 | | |