State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0132	A. BUILDING: ______ B. WING ______	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

(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 An unannounced biennial State Licensure survey was conducted 8/10/2021 through 8/12//2021. Corrections are required for compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 31 certified bed facility was 24 at the time of the survey. The survey sample consisted of 12 current Resident reviews and 5 closed record reviews.	F 000	F 000 Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-140. Policies and procedures. Based on staff interview and facility document review, it was determined that the facility staff failed to ensure their policies and procedures included medical direction and physician services, social services and clinical records. The findings include: On 8/12/21 at 9:27 a.m., review of all facility policies and procedures was conducted with ASM (administrative staff member) #3 (the associate executive director). ASM #3 stated the facility reviews all policies and procedures annually; however, the corporate office had completed a policy update review in order to standardize all policies for all facilities in multiple states and the facility did not have policies for medical direction and physician services, social services and clinical records. ASM #3 was made aware that this was a concern.	F 001	**A. With respect to the specific resident/situation cited:** The Governing Body was notified of need for policy regarding Medical Direction and Physician Services, Social Services and Clinical Records. Guidelines were provided pending policy confirmation. **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Skilled Nursing Administrator/designee will conduct an audit review of current policy and procedures compared to the regulatory requirement. Findings will be referred to the Governing Body for policy development and implementation. **C. With respect to what systemic measures have been put into place to address the stated concern:** The community interdisciplinary team will coordinate an annual review of policies and procedures with Governing Body assessment of regulatory requirements.	09/14/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scarlett Huang
TITLE: LNHA
(X6) DATE: 08/25/2021

State of Virginia

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F 001	Continued From page 1 The facility policy titled, "Governing Body documented, "2. The general responsibilities of the Governing Body include: b. Overseeing and establishing policies and procedures for the management and operations of the skilled community..." No further information was presented prior to exit. 12VAC5-371-140. Policies and procedures. Based on staff interview and facility document review, it was determined that the facility staff failed to evidence license verification upon hire for one of 20 employee record reviews. The facility staff failed to evidence that RN (registered nurse) #1's nursing license was verified upon hire on 1/5/21. The findings include: Review of RN #1's employee record failed to reveal a nursing license was verified upon hire on 1/5/21. There was no evidence of license verification until 4/8/21. On 8/11/21 at 10:22 a.m., an interview was conducted with OSM (other staff member) #5 (the human resources manager). OSM #5 stated she verifies nurses' licenses before they begin employment. OSM #5 stated she did not have a license verification for when RN #1 was hired and she probably shredded it when she placed the 4/8/21 license verification in the file. On 8/11/21 at 5:06 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 001	**D. With respect to how the plan of correction will be monitored:** The findings from the Policy and Procedure audit will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings for the next 3 months. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Skilled Nursing Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Skilled Nursing Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.	

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F 001	Continued From page 2 The facility policy titled, "Abuse, Neglect & Exploitation- Prevention, Reporting and Investigation" documented, "The community (facility) must not employ or otherwise engage individuals who: III. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property..." No further information was presented prior to exit. 12VAC5-371-300. Pharmaceutical services - cross reference to F761. 12VAC5-371-360. Clinical records - cross reference to F842. 12VAC5-371-370. Maintenance and housekeeping - cross reference to F814.	F 001	**A. With respect to the specific resident/situation cited:** The license for the RN#1 was re-verified on 08/25/2021 and found to be current and in good standing. **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** An audit of employee files for licensed employees in the skilled nursing center will be conducted by the Human Resources Manager/designee by 09/03/2021 to verify that professional licenses are valid and current. **C. With respect to what systemic measures have been put into place to address the stated concern:** The Skilled Nursing Administrator /designee will conduct a weekly audit skilled nursing new hire files to confirm that professional licenses have been verified within 30 days of hire prior to the individual beginning work at the facility. **D. With respect to how the plan of correction will be monitored:** Findings from the new hire audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Skilled Nursing Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Skilled Nursing Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.	09/14/2021