State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2586	A. BUILDING: _____ B. WING _____	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE NORTHERN VIRGINIA	5000 FAIRBANKS AVENUE ALEXANDRIA, VA 22311

(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 Inspection was conducted 4/12/22 through 4/14/22. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. One complaint, #2021-0033--Unsubstantiated, was investigated during the survey. The census in this 121 licensed bed facility was 19 at the time of the survey. The survey sample consisted of 4 resident reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-110 (B)(3)--Management & Administration Based on clinical record review, staff interview, and facility documentation review, the facility staff failed to comply with its own policy regarding Discharge Summary. The findings included: On 4/13/22, the clinical record for Resident #4 was reviewed in its entirety, with particular attention to the discharge process for Resident #4. Resident #4 was discharged on 11/9/21. There was no discharge summary or recapitulation in the clinical record. An interview was conducted with the Facility Administrator, the Associate Executive Director (Employee C), and the Director of Nursing (DON) who verified the findings.	F 001	12VAC5-371-110(B)(3) Correct deficiency: Following the identification by the surveyor on 4/12/2022. The Medical Director/primary physician input a late entry discharge summary 4/12/22 for resident #4. Prevent recurrence of deficiency: The director of nursing received an in-service training from the executive director on 4/19/2022 regarding the policy of reviewing and ensuring that all discharges have a discharge summary. Maintain compliance: For the period 4/20/2022 through 12/31/2022, the director of nursing will conduct audits of all discharges to ensure that the resident files have an accurate discharge summary by the physician. Date of completion: 4/28/2022 Director of Nursing, title of person implementing POC.	4/28/2022

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

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F 001	Continued From page 1 Review of the facility's policy entitled, "Discharge Summary", effective date February 2009, states, "A discharge summary will be completed on each resident discharged from the facility" and subheading, "Policy Interpretation and Implementation", read, "1. A discharge summary will be completed on each resident following discharge from Health Care (HC). 1.1 The discharge summary will be completed by the Director of Nursing (DON) or designee and will include the following information: 1.1.1. A recapitulation of the resident's stay" and "2. Discharge Summaries will be: 2.1 Attached to the resident's closed chart". 12 VAC5-371-150 (G)--Resident Rights Based on staff interview and facility documentation review, the facility staff failed to register with the Virginia Department of State Police to receive notice of the registration or reregistration of any sex offender within the same or a contiguous zip code area in which the nursing facility is located. The findings included: On 4/12/22, an interview was conducted with the Facility Administrator and the Associate Executive Director (Employee C) to determine the facility's registration status with the Virginia State Police (VSP) to receive notifications of registered sex offenders within the local area. Employee C stated that she would look into the facility's registration status.	F 001	12 VAC 5-371-150(G) Correct deficiency: The associate executive director registered the Hermitage of Northern Virginia with the department of state police to receive notice of any registered sex offender moving in within the contagious zip code area of the facility. Prevent recurrence of deficiency: The executive director will periodically ensure the registry is current and operating properly. Maintain compliance: For the period 4/20/2022 to 12/31/2022, the executive director will verify the registry's functional status monthly. Date of completion: 04/28/2022 Executive Director, title of person implementing POC.	4/28/2022

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F 001	Continued From page 2 Employee C submitted an email from the Director of Marketing, Admissions that read, "https://sex-offender.vsp.virginia.gov/". Employee C stated, "This is the [VSP] website address that we use to screen potential new residents prior to offering them admission to our facility, however I am not aware of our facility registering with them [VSP] to get notices about people living in the surrounding neighborhoods". On 4/14/22, the Facility Administrator and Employee C stated they were able to successfully register with the Virginia State Police, on 4/13/22, to begin receiving notifications of registered sex-offenders residing around the facility. No further information was provided. 12 VAC5-371-180 (A)--Infection Control Based on observation, staff interview, and facility documentation review, the facility staff failed to maintain infection control practices with regard to visitor screening for COVID-19. The facility staff failed to provide visitor screening for COVID-19 at an unrestricted facility entrance located at the Healthcare Center. The findings included: On 4/12/22 at approximately 9:30 AM, the entrance to the Healthcare Center was observed and found to be locked. Two notices and a sign were posted directly on the front door which read, in ascending order, as follows: First notice--with a red stop sign and bold lettering, "STOP, ATTENTION VISITORS,	F 001	12 VAC 5-371-180(A) Correct deficiency: The director of engineering soon after the identification by the surveyor on 04/12/2022, ensured the entrance door to the Healthcare building was fixed. Prevent recurrence of deficiency: The director of nursing conducted an in-service on 04/15/2022 regarding screening visitors for Covid-19. Maintain compliance: For the period 04/20/2022 to 12/31/2022, the director of nursing or designee will conduct an audit daily of visitors covid-19 screening protocols and procedures. Date of completion: 04/28/2022 Director of Nursing, title of person implementing POC.	04/28/2022

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F 001	Continued From page 3 COVID-19 (Coronavirus), until further notice visitors or guests are not permitted". Second notice--with a red border, "ALL ESSENTIAL PERSONNEL (Vendors, Hospice, Home Health Personnel, Medical Care Team) will be actively screened for the following: If in the LAST 24 HOURS you have had: Fever or feeling feverish, Cough, Sore throat, Shortness of breath OR IF YOU HAVE TRAVELED overseas to an affected area in the last 30 days, You will NOT be permitted to enter the community" and with a green border, "IF YOU ARE PERMITTED: You will be asked to: Have your body temperature checked, To use an alcohol-based hand sanitizer before and after your visit, Limit movement throughout the community and physical contact with residents and others". "The health of our residents and team is our priority. Thank you for helping us keep everyone healthy!". Sign located under second notice--"DOORS WILL BE UNLOCKED AT 8:00 AM UNTIL 7:00 PM AND LOCKED 7:00 PM UNTIL 8:00 AM PLEASE USE INTERCOM" The intercom was used to request entrance due to the locked doors. A voice on the intercom asked, "How can I help you?" and the response, "I am here to perform an inspection, may I come in?" was given. The doors were opened; however, no one was present at the receptionist desk, lobby area, or offices. After a wait of approximately 10 minutes, an individual appeared in the hallway and when asked, he identified himself as the Director of Nursing (DON). The DON was asked who had responded to the intercom and he stated, "The nursing staff on the fourth floor". He was also asked if he had been	F 001		

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F 001	Continued From page 4 notified that a person had been let into the Healthcare Center to perform an inspection and he stated, "No, I just happened to run into you after my morning meeting". The DON stated it was his expectation for any visitor that approached the entrance to the Healthcare Center to be directed to the Assisted Living lobby for COVID screening prior to entry and not "just buzzed in". The DON stated that visitation is not currently restricted, however visitors, vendors, and anyone without a facility badge was expected to report to the Assisted Living lobby, located in the next building, in order to be screened for signs or symptoms of COVID prior to being allowed access throughout the facility. The DON was asked to observe the outside entrance to the Healthcare Center for signage that would indicate that visitors were welcome including any instructions for where to report for COVID screening. The DON confirmed there were no visible signs permitting visitors and no visible signs on the location for COVID screening. On 4/12/22 at approximately 10:30 AM, an Entrance Conference was conducted with the Facility Administrator, the Associate Executive Director (Employee C), and the DON in attendance. The findings at entrance to the facility were discussed. Employee C verified that access to the Healthcare Center was currently restricted in order for all visitors in order to obtain COVID screening through the Assisted Living lobby. Employee C stated that only facility staff with badges who had already been screened for the day were accessing the Healthcare Center front entrance by using their badges, otherwise the doors were expected to remain locked.	F 001		

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F 001	Continued From page 5 On 4/13/22 at approximately 1:30 PM, after returning from a lunchbreak, the entrance to the Healthcare Center was found to be unlocked and unattended. No facility staff were observed in the area as the DON previously confirmed that the reception desk at the Healthcare Center is not staffed. Review of the facility policy entitled, "Visitation Practices During COVID-19 Pandemic", dated April 2021, read, "Policy: Hermitage in Northern Virginia is committed to having systems and processes in place for visitation during the COVID-19 pandemic. Visitation will be accomplished using the core principles of COVID-19 infection prevention... Specific Procedures/Requirements: Core Principles of COVID-19 Infection Prevention. Screening of all who enter the facility for: signs and symptoms of COVID-19, temperature checks. Denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days regardless of the visitor's vaccination status. ". On 4/13/22, at the end of day meeting, the Facility Administrator, Employee C, and the DON were notified of the findings at 1:30 with regard to the unlocked entrance at the Healthcare Center which allowed unrestricted, unsupervised access within the facility by anyone. The Facility Administrator stated, "we may be having some door trouble, we will look into it immediately". No further information was provided. 12 VAC5-371-260 (B)(5)&(8)&(10)&(11)--Staff Development and In-service Training	F 001		

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F 001	Continued From page 6 Based on staff interview and facility documentation review, the facility staff failed to ensure resident care staff received annual in-service training for 3 employees, the Director of Nursing (DON), LPN B, and CNA B, in a sample of 5 employee training records. The facility staff failed to ensure completion of mandated annual in-service training for the DON, LPN B, and CNA B. The findings included: On 4/13/22, a copy of facility training records from 9/1/19 through 4/13/22 was reviewed for the selected employee sample and revealed the following: 1. The DON did not have record of required annual in-service training in the areas of (5) Restraint Use and (11) Prevention/Treatment of Pressure Sores. 2. LPN B did not have record of required annual in-service training in the areas of (5) Restraint Use, (8) Resident Rights, (10) Basic Principles of Cardiopulmonary Resuscitation, and (11) Prevention/Treatment of Pressure Sores. 3. CNA B did not have record of required annual in-service training in the areas of (5) Restraint Use, (10) Heimlich maneuver, and (11) Prevention/Treatment of Pressure Sores. The Facility Administrator, Associate Executive Director, and DON were updated on the findings at the End of Day meeting at approximately 5:00 PM. The DON was given the opportunity to verify the CPR certification status for LPN B and CNA B, however by 6:30 PM, no additional information	F 001	12 VAC 5-371-260(B)(5) & (8) & (10) & (11) Correct deficiency: Following the identification by the surveyor on 04/12/2022 of the failed completion of mandated annual in-service training for the DON, LPN B, and CNA B; the staffing coordinator ensured that DON, LPN B, and CNA B were in good standing on their trainings and the current CPR Certification for LPN B and CNA B as evident in their personnel file. Prevent recurrence of deficiency: The director of nursing received in-service training from the executive director on 04/18/2022 regarding the policy that all team member licenses, and trainings are current. Maintain compliance: For the period 4/20/2022 to 12/31/2022, monthly the director of nursing or designee will review file of team members with the approved checklist to ensure they are all current on required trainings and certifications. Date of completion: 04/28/2022. Director of Nursing, title of person implementing POC.	04/28/2022

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F 001	Continued From page 7 was provided. On 4/14/22 at approximately 10:15 AM, a group interview was conducted with the Facility Administrator, Associate Executive Director, and DON, all of whom verified and concurred with the findings on the previous day regarding staff training. The DON provided a copy of an American Heart Association Basic Life Support/CPR card issued on 4/13/22 for LPN B and stated that LPN B "paid some money last night to get his CPR card". The DON also provided a copy of an American Healthcare Academy Healthcare Provider CPR/AED & Standard First Aid card issued on 4/14/22 for CNA B. The DON concurred it appeared that both cards were very recently obtained. No further information was provided.	F 001		