

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FAIRFAX REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10701 MAIN STREET FAIRFAX, VA 22030
--------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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	<p>Initial Comments</p> <p>An unannounced biennial State Licensure Inspection was conducted 5/3/2022 through 5/5/2022. Corrections are required with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Eight complaints were investigated during the survey, VA00054214-substantiated with deficiency, VA00054135-substantiated with deficiency, VA00053005-substantiated without deficiency, VA00050870-substantiated without deficiency, VA00050445-unsustantiated without deficiency, VA00050416-unsustantiated without deficiency, VA00050383-substantiated with deficiency and VA00050151-substantiated without deficiency.</p> <p>The census in this 200 bed facility was 183 at the time of the survey. The survey sample consisted of 42 current Resident reviews and 13 closed record reviews.</p>	F 000		
F 001	<p>Non Compliance</p> <p>The facility was out of compliance with the following state licensure requirements:</p> <p>This RULE: is not met as evidenced by: 12VAC5-371-140. Policies and procedures cross reference to F700.</p> <p>12VAC5-371-250. Resident assessment and care planning cross reference to F656 12VAC5-371-150 A Resident rights cross reference to F550.</p> <p>12VAC5-371-220 A Nursing services cross reference to F698.</p> <p>12VAC5-371-250 G Resident assessment and care planning cross reference to F656.</p>	F 001	<p>12VAC5-371-140. Policies and procedures cross reference to F700.</p> <p>12VAC5-371-250. Resident assessment and care planning cross reference to F656</p> <p>12VAC5-371-150 A Resident rights cross reference to F550.</p> <p>12VAC5-371-220 A Nursing services cross reference to F698.</p>	6/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/18/22

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FAIRFAX REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10701 MAIN STREET FAIRFAX, VA 22030
--------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 001	<p>Continued From page 1</p> <p>12VAC5-371-370 K Maintenance and housekeeping cross reference to F814.</p> <p>12VAC5-371-220. Nursing Services cross reference to F583.</p> <p>12VAC5-371-220. Nursing Services cross reference to F580.</p> <p>12VAC5-371-200. Director of nursing cross reference to F658.</p> <p>12VAC5-371-280 - Activities cross reference to F679.</p> <p>12VAC5-371-220. Quality of Care cross reference to F684.</p> <p>12VAC5-371-220. Nursing Services cross reference to F755</p> <p>12VAC5-371-250 B.2 Resident Assessment and Care Planning cross reference to F637.</p> <p>12VAC5-371-250 F Resident Assessment and Care Planning cross reference to F656.</p> <p>12VAC5-371-220 Quality of Care cross reference to F700.</p> <p>12VAC5-371-140 E.3 Policies and Procedures: Based on staff interview and facility document review, it was determined that the facility staff failed to evidence criminal background check within 30 days of hire and/or from the Virginia State Police for 16 out of 25 staff and primary source verification of current professional license in accordance with the laws of the State of Virginia, for 10 of 25 employee records reviewed.</p> <p>The findings include:</p>	F 001	<p>12VAC5-371-250 G Resident assessment and care planning cross reference to F656.</p> <p>12VAC5-371-370 K Maintenance and housekeeping cross reference to F814.</p> <p>12VAC5-371-220. Nursing Services cross reference to F583.</p> <p>12VAC5-371-220. Nursing Services cross reference to F580.</p> <p>12VAC5-371-200. Director of nursing cross reference to F658.</p> <p>12VAC5-371-280 - Activities cross reference to F679.</p> <p>12VAC5-371-220. Quality of Care cross reference to F684.</p> <p>12VAC5-371-220. Nursing Services cross reference to F755</p> <p>12VAC5-371-250 B.2 Resident Assessment and Care Planning cross reference to F637.</p> <p>12VAC5-371-250 F Resident Assessment and Care Planning cross reference to F656.</p> <p>12VAC5-371-220 Quality of Care cross reference to F700.</p>	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FAIRFAX REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10701 MAIN STREET FAIRFAX, VA 22030
--------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 001	<p>Continued From page 2</p> <p>On 5/4/22 at approximately 3:30 PM, the employee records for newly hired employees within the past two years were reviewed. Review of the employee records failed to produce evidence of criminal background checks within 30 days of hire and/or from the Virginia State Police for 16 out of 25 staff and primary source verification of current professional license in accordance with the laws of the State of Virginia, for 10 of 25 employee records reviewed. The total employee records that failed to evidence required documentation are 18 of 25 records reviewed.</p> <p>The employees identified were:</p> <ol style="list-style-type: none"> 1. RN (registered nurse) #4's employee record documented they were hired as a RN with the facility on 8/11/21. Further review of RN #4's employee record failed to evidence a background check done within 30 days of hire by the Virginia State Police. Background check was performed by another company and dated 8/2/21. There was no evidence of primary source verification from the Virginia Department of Health Professionals and no evidence of reference checks. 2. LPN (licensed practical nurse) #6 employee record documented they were hired as a LPN with the facility on 1/20/21. Further review of LPN #6's employee record failed to evidence a sworn statement and background check done within 30 days of hire by the Virginia State Police. Background check was completed on 3/23/22. 3. LPN #7 employee record documented they were hired as a LPN by the facility on 12/17/20. Further review of LPN #7's employee record 	F 001	<p>12VAC5-371-140</p> <ol style="list-style-type: none"> 1. Current employee VA state police background check, sworn statements, reference checks, and license have all been obtained and in employee files. 2. An audit of current employee files will be conducted by Human Resources Director or designee to verify VA state police background check, sworn statements, reference checks, and license have all been obtained and in employee file. 3. The Administrator or designee will in-service the Human Resource Director on the process for obtaining and maintaining records in the employee file of the verifications for VA state police background check, sworn statements, reference checks, and license have been obtained prior to hire. 4. Audits will be conducted to VA state police background check, sworn statements, reference checks, and license were obtained prior to hire and verification are maintained in the employee file weekly x 4 then monthly x 2. The audit findings will be reviewed and/or revised in the QAPI meeting monthly for the next 3 months. 	
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FAIRFAX REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10701 MAIN STREET FAIRFAX, VA 22030
--------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 001	<p>Continued From page 3</p> <p>failed to evidence a background check done within 30 days of hire by the Virginia State Police. Background check was completed on 3/20/22.</p> <p>4. CNA (certified nursing assistant) #4's employee record documented they were hired as a CNA with the facility on 1/4/21. Further review of CNA #4's employee record failed to evidence a background check done within 30 days of hire by the Virginia State Police. Background check was performed by another company and dated 12/15/20. Primary source verification from the Virginia Department of Health Professionals for a certified nursing assistant with expiration date of 2/28/21. Employee left the facility on 9/26/21. There were no reference checks.</p> <p>5. CNA #5's employee record documented they were hired as a CNA with the facility on 11/17/20. Further review of CNA #5's employee record failed to evidence a sworn statement and a background check done within 30 days of hire by the Virginia State Police. There was no primary source verification from the Virginia Department of Health Professionals for a certified nursing assistant. There were no reference checks.</p> <p>6. CNA #6's employee record documented they were hired as a CNA with the facility on 2/11/21. Further review of CNA #6's employee record failed to evidence a primary source verification from the Virginia Department of Health Professionals for a certified nursing assistant. There were no reference checks.</p> <p>7. CNA #7's employee record documented they were hired as a CNA with the facility on 3/24/21. Further review of CNA #7's employee record failed to evidence a sworn statement and a background check done within 30 days of hire by</p>	F 001		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FAIRFAX REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10701 MAIN STREET FAIRFAX, VA 22030
--------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 001	<p>Continued From page 4</p> <p>the Virginia State Police. Background check was performed by another company and dated 2/21/21. There was no primary source verification from the Virginia Department of Health Professionals for a certified nursing assistant. There were no reference checks.</p> <p>8. CNA #8's employee record documented they were hired as a CNA with the facility on 3/29/21. Further review of CNA #7's employee record failed to evidence a primary source verification from the Virginia Department of Health Professionals for a certified nursing assistant. There were no reference checks.</p> <p>9. CNA #9's employee record documented they were hired as a CNA with the facility on 1/7/21. Further review of CNA #9's employee record failed to evidence a background check done within 30 days of hire by the Virginia State Police. Background check was performed by another company and dated 12/18/20. There were no reference checks.</p> <p>10. CNA #10's employee record documented they were hired as a CNA with the facility on 6/30/21. Further review of CNA #10's employee record failed to evidence a sworn statement and a background check done within 30 days of hire by the Virginia State Police. Background check was performed on 3/20/22. There was no primary source verification from the Virginia Department of Health Professionals for a certified nursing assistant.</p> <p>11. CNA #11's employee record documented they were hired as a CNA with the facility on 4/7/21. Further review of CNA #11's employee record failed to evidence a sworn statement and a background check done within 30 days of hire by</p>	F 001		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FAIRFAX REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10701 MAIN STREET FAIRFAX, VA 22030
--------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 001	<p>Continued From page 5</p> <p>the Virginia State Police. Background check was performed on 3/20/22. Sworn statement was done on 3/24/22.</p> <p>12. CNA #12's employee record documented they were hired as a CNA with the facility on 3/1/21. Further review of CNA #12's employee record failed to evidence a sworn statement and a background check done within 30 days of hire by the Virginia State Police. Background check was performed by another company and dated 3/1/21. There was no primary source verification from the Virginia Department of Health Professionals for a certified nursing assistant. There were no reference checks.</p> <p>13. CNA #13's employee record documented they were hired as a CNA with the facility on 5/6/21. Further review of CNA #13's employee record failed to evidence a sworn statement and a background check done within 30 days of hire by the Virginia State Police. Background check was performed by another company and dated 5/24/21. There was no primary source verification from the Virginia Department of Health Professionals for a certified nursing assistant. There were no reference checks.</p> <p>14. OSM (other staff member) #7's employee record documented they were hired as an OT (occupational therapist) with the facility on 12/8/20. Further review of OSM #7's employee record failed to evidence a background check done within 30 days of hire by the Virginia State Police. Background check was performed by another company and dated 12/18/20. There were no reference checks.</p> <p>15. OSM #8's employee record documented they were hired as an OT (occupational therapist) with</p>	F 001		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FAIRFAX REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10701 MAIN STREET FAIRFAX, VA 22030
--------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 001	<p>Continued From page 6</p> <p>the facility on 2/15/21. Further review of OSM #8's employee record failed to evidence a background check done within 30 days of hire by the Virginia State Police. Background check was performed by the Virginia State Police and dated 3/23/22.</p> <p>16. OSM #9's employee record documented they were hired as a SLP (speech language pathologist) with the facility on 11/16/20. Further review of OSM #9's employee record failed to evidence a sworn statement and a background check done within 30 days of hire by the Virginia State Police. Background check was performed by another company and dated 12/2/20. There was no primary source verification from the Virginia Department of Health Professionals for a SLP. There were no reference checks.</p> <p>17. OSM #10's employee record documented they were hired as an OT with the facility on 12/9/20. Further review of OSM #10's employee record failed to evidence a background check done within 30 days of hire by the Virginia State Police. Background check was performed by another company and dated 12/7/20. There were no reference checks.</p> <p>18. OSM #11's employee record documented they were hired as an admissions coordinator on 11/30/20 with the facility. Further review of OSM #11's employee record failed to evidence a sworn statement and a background check done within 30 days of hire by the Virginia State Police. There were no reference checks.</p> <p>An interview was conducted on 5/4/22 at 2:34 PM with OSM #1, the human resources director. When asked when she started at the facility, OSM #1 stated, I was hired the end of October</p>	F 001		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FAIRFAX REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10701 MAIN STREET FAIRFAX, VA 22030
--------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 001	<p>Continued From page 7</p> <p>2021. When asked about the employee files lack of evidence on required documents, OSM #1 stated, the files of the staff hired before I got here are the ones we cannot find the information on. We've looked in multiple classrooms and have not been able to get further information from the previous corporation that owned this building. We did an audit and put a QAPI (quality assurance performance improvement) plan in place. When asked if there was a completion date for the QAPI plan, OSM #1 stated, it is ongoing as we are trying to get all the files up to date. OSM #1 stated, I will bring you a copy of the QAPI plan.</p> <p>Per the QAPI 3/24/22 agenda under the areas reviewed:</p> <ol style="list-style-type: none"> 12/10/21 Employee background checks are not being obtained from Virginia State Police per regulation. 3/24/22 for the month of February, background checks are at 15% completion. HR (human resources) director will initiate a plan to get these items into compliance by 3/31/22. 12/10/21 Employee sworn statements failed to be obtained from current employees upon hire. 3/24/22 for the month of February there were no sworn statements obtained. HR director will initiate a plan to get these items into compliance by 3/31/22. 12/10/21 Employee reference checks are not being conducted prior to hire and/or upon hire. 3/24/22 for the month of February there were no reference checks obtained. HR director will initiate a plan to get these items into compliance by 3/31/22. <p>On 5/4/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator, ASM #3, the regional vice president of operations, ASM #4, the vice president of clinical services and ASM #6, the assistant administrator were made aware</p>	F 001		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FAIRFAX REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10701 MAIN STREET FAIRFAX, VA 22030
--------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 001	<p>Continued From page 8</p> <p>of the above concerns</p> <p>After the concerns regarding the employee files were discussed, ASM #1, the administrator stated, "The files were a mess, we could not get information from the previous corporation. Our action plan is to be completed by the end of this month. For any new hires since the new HR director came, the files are good. We went and corrected current employee files with the required documents. We did not go back to the employee's files who have left to update their documents."</p> <p>According to the facility's "Employment" policy dated 1/1/20, "Before you commence your employment, you must complete several administrative and security measures. Specifically you must complete a sworn statement. The company will also conduct a background and reference check. Any offers of employment are entirely conditional on the successful completion of these items. Employment or continued employment depends upon a successful completion of the criminal background check. Person's hired as part of the professional staff of the facility are required to have and maintain a valid current license or certification issues by the state in which he or she works. The facility will also conduct a verification of licenses to verify status of said license prior to start date."</p> <p>No further information was provided prior to exit.</p>	F 001		