Mount Vernon
HEALTHCARE CENTER
Serving with Pride.

February 17, 2023

RE: Mount Vernon Healthcare Center
Provider Number 495211

Mr. Paul Wade
LTC Supervisor
VDH-Office of Licensure and Certification
9960 Mayland Drive
Henrico, VA 22306

Dear Mr. Wade:

Please see the enclosed plan of correction for the survey revisit on February 14-15, 2023. Our allegation of compliance date is February 22, 2023.

I can be reached at the enclosed number or email for any questions.

Sincerely,

Kim Porter, LNHA
Executive Director

Enclosure

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 _____	R-C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTHCARE CENTER	8111 TISWELL DRIVE ALEXANDRIA, VA 22306

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{E 000}	Initial Comments n/a	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid second revisit to the standard survey, conducted 09/12/2022 through 09/22/2022, was conducted 02/14/2023 through 02/15/2023. The first revisit to the standard survey was conducted 01/04/2023 through 01/11/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long-Term Care Requirements. No complaints were investigated during the survey. The census in this 130 certified bed facility was 100 at the time of the survey. The survey sample consisted of 21 resident reviews.	{F 000}	This Center is submitting this plan of correction to comply with applicable laws, not as an admission or statement of agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations, the Center has taken the actions set forth in the following plan of correction. This plan of correction constitutes the Center's allegation of compliance such that all alleged deficiencies have been or will be corrected by dates indicated above.	
{F 584} SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	{F 584}	1. Bathroom repairs for resident #2111 were completed by maintenance staff on 2/15/23. Repairs included removal of wall paper, repairs, and painting the bathroom walls. 2. 100% of all residents and bathrooms will be completed by the Divisional Facilities manager. Issues identified will be scheduled for repairs on a project calendar. 3. Divisional Facilites Manager will in-service maintenance staff on a Room Repair Project Calendar to ensure resident rooms and/or bathrooms and restrooms are completed as scheduled.	

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

Kimberly Porter — 2/17/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 584}	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility documentation the facility staff failed to ensure a safe, clean, comfortable, and homelike environment for 1 Resident (#2111) in a survey sample of 21 Residents. The findings included: For Resident #2111, the Residents bathroom wallpaper was missing in some areas and peeling and not adhered to the wall in other areas. On 2/14/23 at approximately 9:45 AM observations were made of Resident #2111's bathroom. The observation revealed there was a large section of wallpaper missing below the	{F 584}	Administrator or designee will audit room project schedule weekly to ensure repairs have been completed as identified. Work orders also will be reviewed weekly to ensure new maintenance requests are completed. Audits will continue weekly for 8 weeks, then monthly times 3. Audits will be reviewed by Quality Assurance Performance Improvement Committee (QAPI) monthly to determine continued monitoring or corrective action.	2/22/23

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{F 584}	Continued From page 2 paper towel dispenser. The missing area measured approximately 6 inches long and approximately 16 inches wide. Additionally, there was a significant amount of wallpaper throughout the bathroom which was peeling and was not adhered to the wall near the sink and under the sink. On 2/14/23 at approximately 10:30 AM the Administrator and the Maintenance director were accompanied by Surveyor D to look at the bathroom. When the Administrator looked at the room, she stated that she must have put the wrong room in the Tels system (Tels is the system used to track and request maintenance orders). When asked if this should have been caught on the "Ambassador Rounds" she stated that it should. Review of the maintenance work orders from January, until the time of survey revealed no listing of Resident #2111's room being communicated to maintenance. A review of the Ambassador Rounds revealed that no one reported the issues in Resident 2111's room. While reviewing the Ambassador Round sheets a note was found signed by the Administrator and it stated that Maintenance completed bathroom repairs for Resident 2111's bathroom on 2/3/23. On 2/14/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	{F 584}		
{F 625} SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	{F 625}		

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{F 625}	Continued From page 3 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide written information to the Resident or Resident representative at the time of transfer for 1 Resident (Resident #2135) in a survey sample of 21 Residents. The findings included: For Resident #2135, the facility staff failed to provide within 24 hours of urgent transfer to the	{F 625}		

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{F 625}	Continued From page 4 hospital, written notice of the bed-hold policy. On the morning of 2/14/23, a closed clinical record review was conducted of Resident #2135's chart. This review included but was not limited to review of the nursing notes and miscellaneous tab of the chart. There was a progress note written by LPN B on 2/11/23 at 15:18, that read, "Resident noted with altered mental status, shivering, hypotension, tachycardia and complaining of pain. Convergence [on-call doctor] was notified and an order was given to send resident to the ER, resident was given Tylenol prior to transfer. Resident was picked up by 911 around 1:50pm. Resident's niece was called and left a message to back the facility [sic]. A follow up call was done, and this writer talked with the ER nurse [name redacted] and she stated that resident will be admitted with a diagnosis of A-FIB, pneumonia and also being Tachycardic". The review revealed no evidence that Resident #2135, nor the Resident's representative were given any written notice of the bed hold policy. On 2/14/23 at 11:48 AM, an interview was conducted with LPN B. LPN B was asked about the day Resident #2135 was sent to the hospital. LPN B gave an account of the events and when listing the documents that were provided to the Resident/Emergency Medical staff who transported the Resident, LPN B stated, "order summary and face sheet". LPN B went on to describe that these documents are a "listing of the Resident's medications, diet, orders, lab work and demographics". LPN B went on to report that	{F 625}	1. LPN B was unable to reach Resident #2135 at time of transfer to hospital on 2/11/23. Resident #2135 was readmitted to facility on 2/15/23 to the same room. No payment for bed hold was required by the resident or representative. 2. All residents have the potential to be affected. 3. Licensed nurses will be educated on Bed Hold Policy to ensure residents or their representatives receive notice of Bed Hold at time of transfer. Education will include ensuring a copy of the bed hold policy is provided to the resident or representative at time of transfer. If unable to provide notice to resident or RP, a copy of the bed hold policy will be sent with resident upon transfer. Admissions or designee will follow up with resident/RP on the next business day if unable to provide notice upon transfer. 4. DON or designee will audit discharges daily to ensure bed hold notices were provided upon transfer. Audits will continue daily for 14 days, then weekly for 4 weeks, then monthly times 3. Issues identified will be addressed immediately. Audit findings will be reviewed monthly by QAPI.	2/22/23

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{F 625}	Continued From page 5 she was not able to reach the Resident's representative on that day, to discuss the transfer of Resident #2135 to the hospital. During the above interview, LPN B was asked if she provided any information/forms regarding the bed hold policy. LPN B stated, "Social Services handles that". When asked to clarify when Social Services would notify the Resident and family, LPN B said, "Because it's the weekend, when they come in on Monday". LPN B stated that Resident #2135's family came to the facility on 2/12/23 and reported that they were out of town on 2/11/23 and had just received the message. The family had come to the facility to pick up Resident #2135's belongings. On 2/14/23 at 3 PM, an interview was conducted with Employee C, the social services designee, and Employee D the social services director. When asked to explain the bed hold process when a Resident is transferred to the hospital, Employees C and D stated, "the admissions director makes a phone call to the family the day after discharge. They call and we send a letter certified to the family which helps them understand if they want to hold the bed, the price and the process". Employee C provided the survey team with a book that contained copies of letters sent to Residents/Resident representatives regarding bed hold information. This review revealed a letter dated 2/13/23, that was addressed to Resident #2135's family member. This was 2 days post-transfer to the hospital and was being mailed.	{F 625}		

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{F 625}	Continued From page 6 A review of the facility policy titled; "Bed Hold Policy" was conducted. This policy read, "1. In the event a resident returns to the hospital or goes on a leave, the following process will be followed by the facility: a. The admissions director or designee will notify the resident and/or responsible party of the days available under their Medicaid benefits or the private pay cost associated with holding the bed will be explained, within 24 hours of the patient leaving the facility, or the following business day if the patient leaves on the weekend or a holiday. b. The nurse or designee will obtain the residents or responsible party's signature on the bed hold authorization form each time the resident leaves on a bed hold. If the bed hold authorization form cannot be signed prior to the resident leaving and needs to be mailed, it must be mailed certified return receipt requested by the Business Office Manager or designee. c. The Director of Social Service or designee will notify the resident or responsible party if a room reassignment is required..." On the afternoon of 2/15/23, during an end of day meeting, the facility Administrator was made aware that the facility policy with regards to bed hold does not align with the regulatory requirement of written notice being provided at the time of transfer. During the end of day meeting the facility Administration accessed Resident #2135's electronic record and showed the survey team a document titled, "COVID Hospital Transfer Form". In section "H" of this form, it read, "1. SNF to ED or Outpatient Clinic Transfer Checklist: Print the following documents and include with this Transfer Form in the order listed. Send entire	{F 625}		

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{F 625}	Continued From page 7 packet with the patient to the hospital. a. bed hold [which was checked] b. Care Plans [which was checked] c. Face Sheet/Admission record [which was checked] d. Lab Results [which was checked] ...". During the end of day meeting the facility Administration also had LPN B come to the conference room. When asked about Resident #2135's transfer to the hospital on 2/11/23 and shown the "COVID Hospital Transfer Form" and asked if she printed any additional forms and provided to the Resident at the time of transfer, LPN B said, she printed the COVID Hospital Transfer Form, but no other documents with regards to bed hold because the social worker handles that. LPN B confirmed that other than this box being checked on this form, no discussion or form with the bed hold policy and information was provided. No further information was provided.	{F 625}		
{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure necessary services to maintain good personal hygiene for 1 Resident (#2133) in a survey sample of 21 Residents. The findings included:	{F 677}	1. Resident #2133 received am care by nursing staff on 2/14/23 when re-attempted before 10am. Documentation of refusals and then care provided were entered as late entry documentation by LPN C. 2. All residents have the potential to be affected. An audit of ADL current residents. Residents noted with refusal of care will be audited to assure refusals of care is documented on behavior monitoring and POC records are completed accurately to reflect resident refusals.	

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{F 677}	Continued From page 8 For Resident #2133, the facility staff failed to provide adequate incontinent care and bathing services to maintain good personal hygiene. On 02/14/23 at 9:45 AM, Surveyor D entered the room of Resident #2133 and a strong odor of ammonia was present. The smell got stronger the further into the room toward B Bed which was near the window. Surveyor D then went into the hall and found LPN C working on the unit and asked her to come to Resident 2133's room. When the LPN C entered the room, she was asked to identify any odors she smelled and she stated at first, she smelled urine, then as she walked further into the room it smelled very strongly of ammonia. When asked to identify why that would be she stated that someone was incontinent and sitting in it for a while. She identified the odor as coming from Resident 2133 who was in the bed nearest the window. LPN C and Surveyor D then found CNA B who was assigned to Resident 2133 asked about when the last time Resident #2133 was provided incontinent care. CNA B stated that Resident 2133 has "Dementia and won't let us change him." Surveyor D, LPN C and CNA B then went into the room to ask the Resident if he would allow staff to provide incontinent care. Surveyor D stood out of the line of vision of the Resident and the Nurse asked the Resident if he would allow the CNA to change his incontinent brief and linens as they were soiled as well, the Resident was very cooperative and said, "Yes that's fine." The CNA and LPN exited the room and went to gather supplies to provide incontinent care. On 2/14/23 at approximately 11:00 AM an interview was conducted with the LPN who stated	{F 677}	3. Nursing staff will be educated on ADL care, including documentation of refusal of care is noted; and interventions provided per plan of care. 4. DON or designee will audit ADL records daily to ensure refusal of care and interventions are documented in the residents' record. Issues identified will be corrected. Audits will be completed daily for 14 days, then weekly for 4 weeks, then monthly times 3. Audit will be reviewed by QAPI monthly to determine corrective action and/or continued monitoring.	2/22/23

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{F 677}	Continued From page 9 that Resident #2133 was saturated with urine, and he did allow staff to get him cleaned up and change linens and she stated that they wiped his mattress down with bleach wipes as well. On 2/15/23 a review of the POC (Point of Care) CNA documentation record revealed that during the month of January Resident #2133 had no refusals that were documented. During the month of February (from the 1st until the 14th), Resident #2133 had 1 refusal documented on 2/8/23 at 9:21 PM. On the POC record the box for "Behavior Monitoring & Interventions" all the boxes for all the shifts in January and February 2023 were marked "NB" (No Behaviors). A review of the Nursing Progress Notes revealed that there has been no documentation of refusal of care in January or February of 2023. On 2/15/23 at approximately 4:30 PM an interview was conducted with the Regional Nurse, the DON, and the Administrator was held and concerns about the incontinent care and hygiene for Resident 2133's was discussed. The DON was asked the expectation if a Resident refuses care, she stated she would expect the CNA to give the Resident a few minutes and re-approach him or her. When asked if consistent refusals or repeated refusals were expected to be documented and she stated that they were. When asked did she expect the behaviors to be documented in the nurse's notes and she stated that it was. When asked about bathing expectations she stated that Residents receive 2 showers a week and bed bath daily if they allow it. She stated that Residents who refuse showers should at least have a bed bath daily.	{F 677}		

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{F 677}	Continued From page 10 The regional nurse stated the Resident was care planned for refusing care. When asked if being care planned for refusing care means he does not have to be provided incontinent care she stated no. When asked if refusal of care should be documented so that it may be addressed during care plan meetings, she indicated that it should be documented. A review of the care plan revealed a plan for shower refusal but there was nothing concerning ADL care related to refusal of toileting or hygiene. On 2/15/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. –	{F 677}		