State of Virginia

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	ETED
			B. WING		C	
		VA0168	B. WING		09/2	29/2022
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
MOUNT V	ERNON HEALTHCARE C	ENTER 8111 TISWI ALEXANDI	ELL DRIVE RIA, VA 22306			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
F 000	000 Initial Comments		F 000			
		ucted 09/12/22 through was not in compliance with d Regulations for the				
	119 at the time of the	0 certified bed facility was survey. The survey sample ent reviews and 23 staff				
F 001	Non Compliance		F 001			
	The facility was out of following state licensu					
	reference F550. 12VAC5-371-150 (A). F554. 12VAC5-371-160(A). F567. 12VAC5-371-160(A). refence to F568. COV 32.1-138 (A)(7). F568. COV 32.1-138 (A). PI F571. 12 VAC 5-371-150 (C) cross reference to F5 COV 32.1-138(A)(3). F577.	& (B)(1). Please cross Please cross reference to Please cross reference to & (C)(1). Please cross Please cross reference to ease cross reference to and (D) and (E). Please 4. Please cross reference to				
	F583. 12VAC5-371-370(A). F584.	Please cross reference to Please cross reference 8) please cross reference to				

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

TITLE

(X6) DATE 12/30/22

State of \	/irginia					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						С
		VA0168	B. WING		l l	29/2022
NAME OF P	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STAT			
NAME OF T	NOVIDEN ON GOLL FIELD		TISWELL DRIVE	E, Zii GOBE		
MOUNT V	ERNON HEALTHCARE (CENTER	ANDRIA, VA 22306			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
F 001	Continued From page	e 1	F 001			
	F602. 12VAC5-371-110(B)(reference to F602. 12 VAC5-371-140 Plef-607 12VAC5-371-250(G). F656. 12 VAC 5-371-250 (C). Please cross reference to F-658 12VAC5-371-220(A). F676. 12VAC5-371-220(D). F677. 12VAC5-371-220 (C). to F-686 12 VAC5-371-220 (C). to F-686 12 VAC 5-371-220 (C). Teference to F-658 12 VAC5-371-220 (C). Teference to F-684 12 VAC5-371-220 (C). Teference to F-686 12 VAC 5-371-220 (C). Teference to F-691 12 VAC5-371-200 (E). Teference to F730. 12 VAC5-371-200 (E). Teference to F730. 12 VAC5-371-200 (E). Teference to F730. 12 VAC5-371-300 (E). Teference to F730. 12 VAC5-371-300 (E). Teference to F730. 12 VAC5-371-200 (E). Teference to F730. 12 VAC5-371-200 (E). Teference to F730.	Please cross reference to Please cross reference C), (F), (G), (H) and (I). Ce to F657. & (B)(1)(ii) Please cross Please cross reference Please cross reference (B), (C)(2) & (D). Please (1) Please cross reference A) and (B) and (C) and (D).				

F880.

12 VAC5-371-180(A). Please cross reference to

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVI	
		A. BUILDING: _			
	VA0168	B. WING		C 09/29/20	022
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOUNT VERNON HEALTHCARE CEN	NTER 8111 TISWE ALEXANDE	ELL DRIVE RIA, VA 22306			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) OMPLETE DATE
prior to hire, for 3 employ #15, in a sample of 25 e reviewed. The facility staff failed to statement for Staff #6, Staff method in Staff met	ease cross reference to compliance with the and Regulations for the incilities: and facility the facility staff failed to ed sworn statement, on or eyees, Staff #6, #10, and employee records b obtain a sworn Staff #10, and Staff #15. 25 employee personnel and revealed the 4/14/21. There was no ed for Staff #6. in 9/1/21. There was no ed for Staff #10. in 3/1/22. There was no ed for Staff #15. Resources (HR) Director infirmed the hire dates for staff members and provide a sworn statement	F 001			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
			A. BUILDING: _			
		VA0168	B. WING		09/2	, 9/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MOUNT V	ERNON HEALTHCARE C	ENTER	ELL DRIVE RIA, VA 22306			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
F 001	person is hired becaud on thave any crimi would keep them from No further information. 12VAC5-371-75(B)(3) Based on staff intervied occumentation review obtain a criminal record Department of State If for 13 employees, Staff 12, #13, #14, #15, # sample of 25 employed. The facility staff failed background check wir #5, #6, #7, #8, #10, # #21, and #23. The findings included. On 9/15/22, a review records was conducted following: 1. Staff #5 was hired on 5/21/21. There was check provided for Staff was unaware of background status and direct care to Resider.	aty Administrator was gs. He stated, "Sworn posed to be obtained before a asse they are saying that they mal or legal issues that in working with the elderly". In was provided. The was provided. The facility staff failed to ard report from the Virginia Police within 30 days of hire aff #5, #6, #7, #8, #10, #11, 16, #21, and #23, in a ge records reviewed. The obtain a criminal thin 30 days of hire for Staff 11, #12, #13, #14, #15, #16, The control of 25 employee personnel ged and revealed the graph of the control of 25 employee personnel ged and revealed the graph of 21 through 5/21/21, facility Staff #5's criminal graph of the control of t	F 001			
		as no criminal background				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
			A. BUILDING: _			
		VA0168	B. WING		1	, 9/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOUNT V	ERNON HEALTHCARE C	ENTER 8111 TISW ALEXAND	ELL DRIVE RIA, VA 22306			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
F 001	Therefore, from 4/14/staff was unaware of background status and direct care to Resider 3. Staff #7 was hired background check was dated 6/1/22. Therefore 6/1/22, facility staff was criminal background sprovide direct care to 4. Staff #8 was hired background check was request of Surveyor of from 5/26/21 through unaware of Staff #8's and was permitted to Residents. 5. Staff #10 was hired on 7/22/22. There was check provided for St 9/1/21 through 7/22/2 of Staff #10's criminal permitted to provide of Staff #11 was hired background check was request of Surveyor of from 10/7/21 through unaware of Staff #11's and was permitted to Residents. 7. Staff #12 was hired background.	aff #6 within 30 days of hire. 21 through 10/11/21, facility Staff #6's criminal Id was permitted to provide Ints. on 5/12/21. A criminal Id sprovided, however it was Id unaware of Staff #7's Id status and was permitted to Residents. on 5/26/21. A criminal Id sprovided upon the Id on 9/15/22. Therefore, Id on 9/15/22, facility staff was Id or griminal background status Id on 9/1/21 and terminated In sprovided direct care to If on 9/1/21 and terminated If #10. Therefore, from If #10. Therefore, from If a criminal background If #10. Therefore, from If I on 10/7/21. A criminal In sprovided upon the I on 9/15/22, facility staff was I on 10/7/21. A criminal In sprovided upon the I on 9/15/22, facility staff was I on 10/7/21. Therefore, I on 10/7/21. Therefore, I on 10/7/22, facility staff was I on scriminal background status I on scriminal background status	F 001			
	check provided for St	aff #12. Therefore, from 2, facility staff was unaware				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		VA0168	B. WING			C / 29/2022
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI	E, ZIP CODE	•	
MOUNT V	ERNON HEALTHCARE C	ENTER	VELL DRIVE DRIA, VA 22306			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
F 001	8. Staff #13 was hired terminated on 5/10/22 background check pro Therefore, from 12/13 staff was unaware of background status and direct care to Resider 9. Staff #14 was hired background check was Surveyor G on 9/15/22 through 9/15/22, facility Staff #14's criminal background check was Surveyor G on 9/15/22 through 9/15/22, facility Staff #15's criminal background check was surveyor G on 9/15/22 through 9/15/22, facility Staff #16's criminal background check was check provided for Staff #16's criminal permitted to provide of 11. Staff #16's criminal permitted to provide of 12. Staff #16's criminal permitted to provide of 12. Staff #21 was hire background check was surveyor G and was permitted to provide of 12. Staff #21 was hire background check was surveyor G and was permitted to provide of 12. Staff was unaw background status and care to Residents.	background status and was lirect care to Residents. I on 12/13/21 and 2. There was no criminal ovided for Staff #13. If/21 through 5/10/22, facility Staff #13's criminal d was permitted to provide hts. I on 12/28/21. A criminal as provided upon request of 2. Therefore, from 12/28/21 hty staff was unaware of ackground status. I don 3/1/22. A criminal as provided upon request of 2. Therefore, from 3/1/22 hty staff was unaware of ackground status. I don 1/4/22 and terminated as no criminal background aff #16. Therefore, from 2, facility staff was unaware background status and lirect care to Residents. I don 5/20/22. A criminal as requested on 9/15/22 by provided by facility staff on pom 5/20/22 through 9/19/22, ware of Staff #21's criminal differentiated to provide direct	F 001			
	13. Staff #23 was hire	ed on 11/18/20. A criminal				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or dorate of the transfer of t	IDENTIFICATION NOMBER.	A. BUILDING: _			
		VA0168	B. WING		C 09/29/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MOUNT V	ERNON HEALTHCARE C	ENTER	'ELL DRIVE RIA, VA 22306			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	ſΕ
F 001	Surveyor G on 9/15/2 through 9/15/22, facility Staff #23's criminal bath permitted to provide on 9/20/22, the Human was interviewed and of the 13 referenced factor on 9/21/22, the Facility informed of the finding background checks a anyone because we're residents are not expectimental history such a further information was 12VAC5-371-150(G) Based on staff interviewed register the facility with State Police to receive registration of any same or a contiguous nursing facility is locator on 9/14/22, an interviewed on 9/14/22, an i	as provided upon request by 2. Therefore, from 11/18/20 ity staff was unaware of ackground status and direct care to Residents. an Resources (HR) Director confirmed the findings for ility staff members. ity Administrator was gs. He stated, "Criminal re obtained before we hire must be certain that our osed to people with a as abuse of any kind". No as provided. ew and facility w, the facility staff failed to the the Virginia Department of e notice of the registration or sex offender within the a zip code area in which the ted. : iew was conducted with the to determine the facility's the the Virginia State Police ications of registered sex	F 001	DETICITION 1)		
	are on the sex offend					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
			A. BUILDING: _			
		VA0168	B. WING		C 09/29/20	22
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MOUNT V	ERNON HEALTHCARE C	ENTER	ELL DRIVE RIA, VA 22306			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CO	(X5) DMPLETE DATE
F 001	Continued From page	÷ 7	F 001			
		er people in the area, I do out this". No further				
	12VAC5-371-210(E)					
	verify the professional direct resident care for #16, #20, #21, and #2 nurse personnel reco	v, the facility staff failed to I license, prior to providing or 6 nurses, Staff #7, #11, 23, in a sample of 9 staff rds reviewed.				
	license was active an state licensing board	I to verify the professional d in good standing with the for Staff #7, #11, #16, #20, allowing them to provide				
	The findings included	:				
	On 9/14/22, a review records was conducted following:	of 9 staff nursing personnel ed and revealed the				
	Therefore, from 5/12/ staff was unaware if S professional nurse an	rerification was dated 6/1/22. 21 through 6/1/22, facility Staff #7 was an active, and in good standing with the Staff #7 was permitted to				
	professional license v 3/18/22. Therefore, fr facility staff was unaw active, professional n	on 10/7/21. Staff #11's rerification was dated om 10/7/21 through 3/18/22, ware if Staff #11 was an urse and in good standing g board. Staff #11 was				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101 2741	or contraction	IDENTIFICATION NO.	A. BUILDING: _			
		VA0168	B. WING		C 09/29/20)22
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOUNT V	ERNON HEALTHCARE C	ENTER 8111 TISWI ALEXANDI	ELL DRIVE RIA, VA 22306			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CO	(X5) OMPLETE DATE
F 001	Continued From page	e 8	F 001			
	permitted to provide of	lirect care to Residents.				
	3. Staff #16 was hired on 3/11/22. There was verification provided be encompassed the duremployment at the fact through 3/11/22, facility #16 was an active, progood standing with the #16 was permitted to Residents. 4. Staff #20 was hired professional license would be staff was unawactive, professional newith the state licensing permitted to provide of 5. Staff #21 was hired professional license would be staff was unawactive, professional license would be staff was unawactive, professional newith the state licensing permitted to provide of 6. Staff #23 was hired professional license would be staff #24 was hired professional license would be staff #25 was hired professional license would be staff was would be staff was was was was was wa	d on 1/4/22 and terminated is no professional license by facility staff that ration of Staff #16's cility. Therefore, from 1/4/22 ity staff was unaware if Staff ofessional nurse and in e state licensing board. Staff provide direct care to d on 5/11/22. Staff #20's rerification was dated om 5/11/22 through 5/15/22, ware if Staff #20 was an urse and in good standing g board. Staff #20 was direct care to Residents. d on 5/20/22. Staff #21's rerification was dated om 5/20/22 through 6/20/22, ware if Staff #21 was an urse and in good standing g board. Staff #21 was an urse and in good standing g board. Staff #21 was an urse and in good standing g board. Staff #21 was direct care to Residents. d on 11/18/20. Staff #23's rerification was obtained at or G on 9/15/22. Therefore, in 9/15/22, facility staff was was an active, professional anding with the state #23 was permitted to				
		confirmed the findings for				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		VA0168	B. WING		C 09/29/2022
	ROVIDER OR SUPPLIER ERNON HEALTHCARE C	8111 TISV	DDRESS, CITY, STA	TE, ZIP CODE	
WICONT	ERNON HEALTHCARE C	ALEXANI	DRIA, VA 22306		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
F 001	Continued From page	9	F 001		
	the 6 referenced facili	ty staff nurses.			
	verifications for anyor license, to be sure the the proper care to our license is free from ar	ty Administrator was gs. He stated, "We obtain ne who holds a professional ey are qualified to provide residents and that their ny disciplinary actions by the []". No further information			
	12VAC5-371-210(F)				
	Based on staff interview and facility documentation review, the facility staff failed to verify the professional license, prior to providing direct resident care for 6 certified nursing assistants (CNAs), Staff #3, #5, #8, #13, #18, and #19, in a sample of 8 staff CNA personnel records reviewed.				
	was active and in goo licensing board for St	I to verify the CNA license of standing with the state aff #3, #5, #8, #13, #18, and them to provide direct			
	The findings included	:			
	On 9/14/22, a review records was conducted following:	of 8 staff CNA personnel ed and revealed the			
	license verification wa from 6/21/22 through unaware if Staff #3 wa and in good standing	on 6/21/22. Staff #3's CNA as dated 7/27/22. Therefore, 7/27/22, facility staff was as an active, licensed CNA with the state licensing ermitted to provide direct			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		VA0168	B. WING		09	C / 29/2022
	ROVIDER OR SUPPLIER	8111 TIS	DDRESS, CITY, STAT	TE, ZIP CODE	·	
MOUNTV	ERNON HEALTHCARE C	ALEXAN	DRIA, VA 22306			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
F 001	Continued From page	: 10	F 001			
	care to Residents.					
	on 5/21/21. There wa verification provided be encompassed the duremployment at the fact 3/12/21 through 5/21/1 unaware if Staff #5 was and in good standing board. Staff #5 was power to Residents. 3. Staff #8 was hired license verification was and was provided on 5/26/21 through 9/15/1 unaware if Staff #8 was and in good standing board. Staff #8 was power to Residents.	oy facility staff that ration of Staff #5's cility. Therefore, from 21, facility staff was as an active, licensed CNA with the state licensing ermitted to provide direct on 5/26/21. Staff #8's CNA as requested by Surveyor G 9/15/22. Therefore, from 22, facility staff was as an active, licensed CNA with the state licensing ermitted to provide direct				
	verification was dated 12/13/21 through 5/10 unaware if Staff #13 v and in good standing	2. Staff #13's CNA license I 3/15/22. Therefore, from				
	license verification was from 3/7/22 through 5 unaware if Staff #18 v and in good standing board. Staff #18 was care to Residents.	I on 3/7/22. Staff #18's CNA as dated 5/15/22. Therefore, /15/22, facility staff was vas an active, licensed CNA with the state licensing permitted to provide direct				
	ธ. Staff #19 was hired	I on 4/14/22 and terminated				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURV	
			A. BUILDING:			
		VA0168	B. WING		C 09/29/2	022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MOUNT V	ERNON HEALTHCARE (CENTER	ELL DRIVE			
	CLIMMADY CT		RIA, VA 22306			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
F 001	Continued From page	e 11	F 001			
	and in good standing board. Staff #19 was care to Residents. On 9/20/22, the Humwas interviewed and the 6 referenced facilinformed of the findin verifications for anyol license, to be sure the proper care to oullicense is free from all	by facility staff that ration of Staff #19's cility. Therefore, from /22, facility staff was was an active, licensed CNA with the state licensing permitted to provide direct an Resources (HR) Director confirmed the findings for ity CNAs.				
	12VAC5-371-260(B)(2,3,5,6,8,9,10,11) & (G)				
	ensure resident care in-service training for Nursing (DON), RN E	v, the facility staff failed to				
		d to ensure completion of service training for the DON, NA C.				
	The findings included	:				
	On 9/13/22, a copy o	f all facility training records				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		VA0168	B. WING		C 09/29/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOUNT V	ERNON HEALTHCARE C	ENTER 8111 TISWI	ELL DRIVE RIA, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
F 001	staff employees was from the Staff Develo and the Facility Admir training records reveal. 1. The DON, hired on record of required and areas of (2) Infection Restraint Use, (8) Re Prevention/Treatment Additionally, there was the requirements for reglect, or exploitation failing to make such a reporting). 2. RN B, hired on 5/12 required annual insection (CPR). however the facility was the conclusion of the such as a co	to the present for 5 facility requested and received pment Coordinator (SDC) nistrator. Review of the aled the following: 13/12/21, did not have nual in-service training in the Prevention and Control, (5) sident Rights, and (11) to f Pressure Sores. Is no record of training on reporting adult abuse, an and the consequences for a required report (mandated) 12/21, did not have record of rivice training in the area of of Cardiopulmonary 13 A CPR card was requested, reas unable to provide one by survey on 9/22/22. 16/21, did not have record service training in the areas into and Control, (3) Fire & es, (5) Restraint Use, (6) (8) Resident Rights, (9) ly Impaired, and (11) to f Pressure Sores. Is no record of training on	F 001			
	of required annual in-	17/21, did not have record service training in the areas ntion and Control, (3) Fire &				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		VA0168	B. WING		C 09/29/2022			
	ROVIDER OR SUPPLIER	8111 TISV	DDRESS, CITY, STATE	DRESS, CITY, STATE, ZIP CODE				
MOUNTV	ERNON HEALTHCARE C	ENTER ALEXANI	DRIA, VA 22306	RIA, 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE			
F 001	Confidentiality/HIPPA Care of the Cognitive Prevention/Treatment Additionally, there was the requirements for r neglect, or exploitatio failing to make such a reporting). On 9/14/22, the Staff (SDC) was interviewed findings for the 4 refe members and stated, computer through Rei [the training] is not on provided, then it was On 9/15/22, the Facili informed of the finding Resources] is respon with training, it is supp day but it doesn't app happening, all of the s are new so they are n training compliance] y On 9/15/22, the HR D stated, "[name redact Coordinator] handles records, I've not been No further information 12VAC5-371-290(B) Based on staff intervice	es, (5) Restraint Use, (6) , (8) Resident Rights, (9) ly Impaired, and (11) tof Pressure Sores. s no record of training on reporting adult abuse, n and the consequences for a required report (mandated Development Coordinator ad and confirmed the renced facility staff "All training is done on the lias training modules, if it the transcripts that were n't done". Ity Administrator was gs. He stated, "HR [Human sible for staff compliance coosed to be monitored every ear that it has been staff in the HR department not monitoring this [staff vet". Interctor was interviewed and led, Staff Development all staff training including a told otherwise".	F 001					
		l license, prior to providing						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		VA0168	B. WING		09/29/2	2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOUNT V	ERNON HEALTHCARE C	ENTER 8111 TISWE ALEXANDE	ELL DRIVE RIA, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) COMPLETE DATE
F 001	Continued From page 14		F 001			
	#10, in a sample of 2 personnel records rev The facility staff failed license was active an	or 1 physical therapist, Staff staff physical therapist viewed. I to verify the professional d in good standing for Staff ner to provide direct resident				
	The findings included	:				
	On 9/14/22, a review of Staff #10's employee personnel record was conducted. Staff #10 was hired on 9/1/21 and terminated on 7/22/22. There was no professional license verification provided for Staff #10. Therefore, from 9/1/21 through 7/22/22, facility staff was unaware if Staff #10 was an active, professional physical therapy assistant and in good standing with the state licensing board. Staff #10 was permitted to provide direct care to Residents.					
		an Resources (HR) Director confirmed the findings for				
	verifications for anyor license, to be sure the the proper care to our license is free from an	ity Administrator was gs. He stated, "We obtain ne who holds a professional ey are qualified to provide r residents and that their ny disciplinary actions by the t]". No further information				