State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING VA0121 04/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5872 HANKS STREET** HIGHLAND RIDGE REHAB CENTER **DUBLIN, VA 24084** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION. (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 000 F 000 Initial Comments An unannounced biennial State Licensure Inspection was conducted 4/24/23 through 4/26/23. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Corrections are required. The census in this 132 certified bed facility was 124 at the time of the survey. The survey sample consisted of 26 current resident reviews and 4 closed record reviews. No complaints were investigated during the survey. F 001 Non Compliance F 001 F-001 The facility was out of compliance with the HR Specialist has requested a following state licensure requirements: Virginia State Police Criminal Background Check and signed Sworn Statement for Employee #21. This RULE: is not met as evidenced by: All employee records were audited Based on staff interview, facility document review, to ensure all statements and Criminal employee record review, and the Code of Background Checks are completed Virginia, the facility staff failed to (a) obtain a The HR Specialist will be educated sworn statement and (b) complete an employee criminal background check through the Virginia that all Criminal Background Checks and State Police for one (1) of 25 new hires Sworn Statements should be completed prior (Employee #21). Employee #21 was a contract to start of employment. employee. The findings included: On the morning of 4/26/23, during the review of facility staff personnel files, Employee #21 was noted to have neither a sworn statement nor a Virginia State Police - Central Criminal Records Exchange background check.

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

(X6) DATE

State of Virginia

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COM	LETED	
A, BUILDING:		
VA0121 B. WING04	26/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAND RIDGE REHAB CENTER 5872 HANKS STREET DUBLIN, VA 24084		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Employee #21 had been interviewed, via phone, on 4/25/23 at 4:45 p.m. Employee #21 reported they came to the facility weekly.  The following is part of the Code of Virginia \$32.1-126.01.:  "Yary person desiring to work at a licensed nursing home shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges, whether within or outside the Commonwealth."  "An unsting home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal record sexchange."  On 4/26/23 at 1:14 p.m., the Administrator provided a copy of a sworn statement was obtained that day. The administrator reported the sworn statement was obtained that day. The administrator reported the contracted group/business Employee #21 works for started working at the facility on 8/23/22; Employee #21 was working for the contracted agency on 8/23/22.  The following information towas found in a facility document titled "Abuse" (this document was not dated): "The organization will screen potential		

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PRINTED: 05/08/2023 FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING \_\_ VA0121 04/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5872 HANKS STREET** HIGHLAND RIDGE REHAB CENTER **DUBLIN, VA 24084** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 001 F 001 Continued From page 3 12 VAC 5-371-360 (E)(11) - cross reference to F661 Maintenance and Housekeeping 12 VAC 5-371-370 (A) - cross reference to F584