(X6) DATE

State of Virginia

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                        | 4                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |                     |                                                                                                                                                                                                                                     | (X3) DATE SURVEY<br>COMPLETED |                          |  |  |
|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------|--|--|
|                                                                                                     |                                                                                                                        |                                                                                                                                           | -                                        |                     | С                                                                                                                                                                                                                                   |                               |                          |  |  |
|                                                                                                     |                                                                                                                        | VA0264                                                                                                                                    | VA0264 B. WING                           |                     |                                                                                                                                                                                                                                     | 05/11/2023                    |                          |  |  |
| NAME OF PI                                                                                          | ROVIDER OR SUPPLIER                                                                                                    | ST                                                                                                                                        | FREET ADDI                               | RESS, CITY, STA     | TE, ZIP CODE                                                                                                                                                                                                                        |                               |                          |  |  |
| 456 E MAIN ST                                                                                       |                                                                                                                        |                                                                                                                                           |                                          |                     |                                                                                                                                                                                                                                     |                               |                          |  |  |
| WAVERLY                                                                                             | REHABILITATION AND I                                                                                                   | HEALTHCARE CEN W                                                                                                                          | AVERLY,                                  | VA 23890            |                                                                                                                                                                                                                                     |                               |                          |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |                                                                                                                                           |                                          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                                                                                                                     |                               | (X5)<br>COMPLETE<br>DATE |  |  |
| F 000                                                                                               | Initial Comments                                                                                                       |                                                                                                                                           |                                          | F 000               |                                                                                                                                                                                                                                     |                               |                          |  |  |
|                                                                                                     | The facility was not in Virginia Rules and Re of Nursing Facilities.  The census in this 12                            | cted 5/09/2023 - 5/11/202<br>compliance with the<br>egulations for the Licensur<br>0 licensed bed facility was<br>survey. The survey samp | e                                        |                     |                                                                                                                                                                                                                                     |                               |                          |  |  |
| F 001                                                                                               | Non Compliance                                                                                                         | ant reviews.                                                                                                                              |                                          | F 001               |                                                                                                                                                                                                                                     | 6                             | 6/12/23                  |  |  |
|                                                                                                     | The facility was out of following state licensu                                                                        |                                                                                                                                           |                                          |                     |                                                                                                                                                                                                                                     |                               |                          |  |  |
|                                                                                                     | This RULE: is not me 12VAC5-371-75(B)(1) Based on staff intervie                                                       |                                                                                                                                           |                                          |                     | The facility is unable to retroactively correct the previous missing sworn statements, criminal backgrounds or                                                                                                                      | ,                             |                          |  |  |
|                                                                                                     | documentation review<br>have evidence of a sig<br>prior to hire, for 11 em                                             | , the facility staff failed to<br>gned sworn statement, on<br>poloyees, (Staff #3, #5, #9<br>18, #19, #24, and #25), in                   | ),                                       |                     | license verifications at time of hire.  2. Staff #3 sworn statement and crimir background has been completed. Sta sworn statement and criminal backgro                                                                              | iff #5                        |                          |  |  |
|                                                                                                     | The findings included                                                                                                  |                                                                                                                                           |                                          |                     | has been completed. Staff #9 sworn statement and license verification completed. Staff #10 license verification                                                                                                                     |                               |                          |  |  |
|                                                                                                     | records was conducted following 11 employed sworn statements on their personnel files/re                               | es did not have signed<br>or before their hire dates i<br>ecords:                                                                         | n                                        |                     | completed. Staff #11 license verificati completed. Staff #13 sworn statement completed. Staff #15 no longer employ here, . Staff # 16 criminal background sworn statement completed, license verified. Staff# 17 criminal backgroun | yed<br>I and                  |                          |  |  |
|                                                                                                     | There was no signed                                                                                                    | de, was hired on 4/11/202<br>sworn statement provided                                                                                     | l.                                       |                     | and sworn statement completed, licen verified. Staff # 18 criminal backgrour and sworn statement completed, licen verified. Staff # 19 criminal backgrou                                                                            | nd<br>se                      |                          |  |  |
|                                                                                                     |                                                                                                                        | de, was hired on 3/7/2021<br>sworn statement provided                                                                                     |                                          |                     | and sworn statement completed, licen                                                                                                                                                                                                |                               |                          |  |  |

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

**Electronically Signed** 

TITLE 05/24/23

STATE FORM 6899 CHNU11 If continuation sheet 1 of 6

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                 |                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                     | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |                                                                                                                                                                                                                               | (X3) DATE SURVEY<br>COMPLETED |  |
|---------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--|
|                                                                                                                     |                                                                                                                                                                                                                                          | -                                                                                      |                                          | С                                                                                                                                                                                                                             |                               |  |
|                                                                                                                     |                                                                                                                                                                                                                                          | VA0264                                                                                 | B. WING                                  |                                                                                                                                                                                                                               | 05/11/2023                    |  |
| NAME OF P                                                                                                           | ROVIDER OR SUPPLIER                                                                                                                                                                                                                      | STREET ADD                                                                             | RESS, CITY, STA                          | TE, ZIP CODE                                                                                                                                                                                                                  |                               |  |
| WAVERLY                                                                                                             | REHABILITATION AND                                                                                                                                                                                                                       | HEALTHCARE CEN 456 E MAIN WAVERLY,                                                     |                                          |                                                                                                                                                                                                                               |                               |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                            | (EACH DEFICIENC                                                                                                                                                                                                                          | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)                                                                                                             | BE COMPLETE                   |  |
| F 001                                                                                                               | Continued From page                                                                                                                                                                                                                      | e 1                                                                                    | F 001                                    |                                                                                                                                                                                                                               |                               |  |
|                                                                                                                     | Staff #9, CNA (Certific hired on 2/14/2023. T statement for Staff #7 after date of hire).                                                                                                                                                | ed Nursing Assistant), was<br>There was no signed sworn<br>7 until 4/27/2023 (2 months |                                          | verified. Staff #20 license verified. Staff #21 license verified. Staff # 24 criminal background and sworn statement completed, license verified. Staff #25 criminal background and sworn staten completed, license verified. | al                            |  |
| Staff #13, CNA (Certified Nursing Assistant), was hired on 10/2/2021. There was no signed sworn statement provided. |                                                                                                                                                                                                                                          | ,                                                                                      |                                          | 3. 100% of employee files have been audited for sworn statements, crimina backgrounds and license verifications                                                                                                               |                               |  |
|                                                                                                                     | was no signed sworn<br>#15 was no longer en<br>facility-termination da                                                                                                                                                                   | ite 2/14/2023.<br>nired on 7/1/2022. There                                             |                                          | 4. Education provided to BOM and AE regarding all new hires will have sword statements, criminal backgrounds and license verifications obtained prior to orientation.                                                         | n                             |  |
|                                                                                                                     | Staff #17 (RN) was hired on 7/1/2022. There was no signed sworn statement provided.  Staff #18 (RN) was hired on 4/1/2021. There was                                                                                                     |                                                                                        |                                          | 5.Administrator will audit all new hire f for sworn statement, criminal backgro and license verifications weekly x 4 weeks, monthly for 4 months.                                                                             |                               |  |
|                                                                                                                     | no signed sworn state Staff #19 (RN) was hi no signed sworn state                                                                                                                                                                        | ired on 7/1/2022. There was                                                            |                                          | 6. Findings of audits will be reviewed QAPI Committee for complete employ file.                                                                                                                                               | ·                             |  |
|                                                                                                                     | Staff #24, Certified O<br>Assistant (COTA) was<br>was no sworn statem                                                                                                                                                                    | s hired on 10/1/2021. There                                                            |                                          |                                                                                                                                                                                                                               |                               |  |
|                                                                                                                     | Staff #25, Physical The<br>hired on 10/1/2021. The<br>statement provided.                                                                                                                                                                | nerapy Assistant (PTA), was<br>here was no sworn                                       |                                          |                                                                                                                                                                                                                               |                               |  |
|                                                                                                                     | On 5/11/2023, the Assistant Business Office Manager/Human Resources (HR) Director was interviewed and stated she was newly hired at the facility seven weeks prior to the beginning of the survey. The HR Director stated she was unable |                                                                                        |                                          |                                                                                                                                                                                                                               |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  VA0264                                                                                 |                                                                                                                                             |                                                          | (X2) MULTIPLE     | CONSTRUCTION                                                |                                  | (X3) DATE SURVEY<br>COMPLETED |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------|-------------------------------------------------------------|----------------------------------|-------------------------------|--|
|                                                                                                                                                                                              |                                                                                                                                             | IDENTIFICATION NUMBER:                                   | A. BUILDING:      |                                                             | COMPI                            |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             |                                                          |                   |                                                             |                                  | С                             |  |
|                                                                                                                                                                                              |                                                                                                                                             | B. WING                                                  |                   | <b>I</b>                                                    | 11/2023                          |                               |  |
| NAME OF D                                                                                                                                                                                    | ROVIDER OR SUPPLIER                                                                                                                         | STREET A                                                 | DDRESS, CITY, STA | TE ZIR CODE                                                 |                                  |                               |  |
| NAME OF I                                                                                                                                                                                    | NOVIDEN ON 3011 EIEN                                                                                                                        | 456 E MA                                                 |                   | KIL, ZII CODL                                               |                                  |                               |  |
| WAVERLY                                                                                                                                                                                      | REHABILITATION AND                                                                                                                          | HEALTHCARE CEN                                           | Y, VA 23890       |                                                             |                                  |                               |  |
| (Y4) ID                                                                                                                                                                                      | SUMMARY S                                                                                                                                   | TATEMENT OF DEFICIENCIES                                 | ID                | PROVIDER'S PLAN OF                                          | CORRECTION                       | (X5)                          |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                                                                                                     | (EACH DEFICIENC                                                                                                                             | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG     | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENCE | ION SHOULD BE<br>THE APPROPRIATE | COMPLETE<br>DATE              |  |
| F 001                                                                                                                                                                                        | Continued From pag                                                                                                                          | e 2                                                      | F 001             |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | _                                                                                                                                           |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             | ocumentation for the new<br>tor confirmed the hire dates |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             | cility staff members and                                 |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             | olle to provide a sworn                                  |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | statement for those                                                                                                                         |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | On 5/11/2023, the Fa                                                                                                                        | acility Administrator and                                |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             | nsultant were informed of the                            |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | _                                                                                                                                           | that sworn statements are                                |                   |                                                             |                                  |                               |  |
| supposed to be obtained on or before a person is                                                                                                                                             |                                                                                                                                             |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | hired. The Corporate                                                                                                                        |                                                          |                   |                                                             |                                  |                               |  |
| Registered Nurses listed as Staff Numbers 16                                                                                                                                                 |                                                                                                                                             |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | through 19 were corporate nursed who helped<br>the facility and the facility did not have any<br>documentation on them. The Corporate Nurse |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             | ere was nobody in the                                    |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             | he time of the employee                                  |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | 1                                                                                                                                           | terview to obtain access to                              |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | the personnel files.                                                                                                                        | She stated that the                                      |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | _                                                                                                                                           | vere listed as employees                                 |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | _                                                                                                                                           | d a name badge in order to                               |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | work in the facility.                                                                                                                       |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | No further informatio                                                                                                                       | n was provided                                           |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | Tro fartifor informatio                                                                                                                     | iii waa praviaca.                                        |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | 12VAC5-371-75(B)(3                                                                                                                          | 3)                                                       |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | Roand on otoff inter-                                                                                                                       | riow and facility                                        |                   |                                                             |                                  |                               |  |
| Based on staff interview and facility documentation review, the facility staff failed to obtain a criminal record report from the Virginia Department of State Police within 30 days of hire |                                                                                                                                             |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | for 10 employees, Staff #3, #5, #14, # 15, #16,<br>#17 #18, #19, #24, and #25, in a sample of 25                                            |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | employee records re                                                                                                                         | •                                                        |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              |                                                                                                                                             |                                                          |                   |                                                             |                                  |                               |  |
|                                                                                                                                                                                              | The findings included                                                                                                                       | d:                                                       |                   |                                                             |                                  |                               |  |
| On 05/11/2023, a review of 25 employee                                                                                                                                                       |                                                                                                                                             |                                                          |                   |                                                             |                                  |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION     |                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |                                                                                                          | (X3) DATE SURVEY<br>COMPLETED |                          |  |
|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------|--|
|                                                         |                                                                                                                                                                                                                    | A. BOILDING.                                       |                                          | С                                                                                                        |                               |                          |  |
| VA0264                                                  |                                                                                                                                                                                                                    | B. WING                                            |                                          | 05/11/2023                                                                                               |                               |                          |  |
| NAME OF P                                               | ROVIDER OR SUPPLIER                                                                                                                                                                                                | STREET ADD                                         | RESS, CITY, STA                          | TE, ZIP CODE                                                                                             |                               |                          |  |
| WAVERLY REHABILITATION AND HEALTHCARE CEN 456 E MAIN ST |                                                                                                                                                                                                                    |                                                    |                                          |                                                                                                          |                               |                          |  |
|                                                         | CLIMMADY CT                                                                                                                                                                                                        | WAVERLY,                                           |                                          | DDOWDEDIS DI ANI OF CODDECTIO                                                                            | \ <u>\</u>                    |                          |  |
| (X4) ID<br>PREFIX<br>TAG                                | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                             |                                                    | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |  |
| F 001                                                   | Continued From page                                                                                                                                                                                                | e 3                                                | F 001                                    |                                                                                                          |                               |                          |  |
|                                                         | personnel records was conducted and revealed the following 10 employees did not have Criminal Background Checks within 30 days of hire:                                                                            |                                                    |                                          |                                                                                                          |                               |                          |  |
|                                                         | Staff #3, a Laundry Aide, was hired on 4/11/2022. There was no criminal background check provided.  Staff #5, a housekeeping staff member, was hired on 3/7/2021. There was no criminal background check provided. |                                                    |                                          |                                                                                                          |                               |                          |  |
|                                                         |                                                                                                                                                                                                                    |                                                    |                                          |                                                                                                          |                               |                          |  |
|                                                         | Staff #15 (RN) was hired on 7/20/2022. There was no criminal background check provided. Staff #15 was no longer employed at the facility-termination date 2/14/2023.                                               |                                                    |                                          |                                                                                                          |                               |                          |  |
|                                                         | Staff #16 (RN) was hired on 7/1/2022. There was no criminal background check provided.                                                                                                                             |                                                    |                                          |                                                                                                          |                               |                          |  |
|                                                         | Staff #17 (RN) was hired on 7/1/2022. There was no criminal background check provided.                                                                                                                             |                                                    |                                          |                                                                                                          |                               |                          |  |
|                                                         | Staff #18 (RN) was hired on 4/1/2021. There was no criminal background check provided.                                                                                                                             |                                                    |                                          |                                                                                                          |                               |                          |  |
|                                                         | Staff #19 (RN) was hired on 7/1/2022. There was no criminal background check provided.                                                                                                                             |                                                    |                                          |                                                                                                          |                               |                          |  |
|                                                         | Staff #24, Certified Occupational Therapy<br>Assistant (COTA) was hired on 10/1/2021. There<br>was no Criminal Background Check obtained until<br>5/11/2023 during the survey.                                     |                                                    |                                          |                                                                                                          |                               |                          |  |
|                                                         | Staff #25, Physical Therapy Assistant (PTA), was hired on 10/1/2021. There was no criminal background check provided.                                                                                              |                                                    |                                          |                                                                                                          |                               |                          |  |
|                                                         | On 5/11/2023, the Assistant Business Office<br>Manager/Human Resources (HR) Director was                                                                                                                           |                                                    |                                          |                                                                                                          |                               |                          |  |

| STATEMENT OF DEFICIENCIES (V4) DROVIDED/CUDDI IED/CUA                                             |                                                                                              | (VO) MULTIPLE                                      | CONCEDUCTION               | (V2) DATE CUDVEV                               |                               |  |  |  |  |
|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------|------------------------------------------------|-------------------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION |                                                | (X3) DATE SURVEY<br>COMPLETED |  |  |  |  |
|                                                                                                   |                                                                                              | A. BUILDING: _                                     |                            | JOINI LETED                                    |                               |  |  |  |  |
|                                                                                                   |                                                                                              |                                                    |                            | С                                              |                               |  |  |  |  |
| VA0264                                                                                            |                                                                                              | B. WING                                            | <del></del>                | 05/11/2023                                     |                               |  |  |  |  |
|                                                                                                   |                                                                                              | •                                                  |                            |                                                |                               |  |  |  |  |
| NAME OF PI                                                                                        | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE                           |                                                    |                            |                                                |                               |  |  |  |  |
| WAVEDIV                                                                                           | PEHARII ITATION AND                                                                          | HEALTHCARE CEN. 456 E MA                           | IN ST                      |                                                |                               |  |  |  |  |
| WAVEILL                                                                                           | WAVERLY REHABILITATION AND HEALTHCARE CEN' WAVERLY, VA 23890                                 |                                                    |                            |                                                |                               |  |  |  |  |
| (X4) ID                                                                                           | SUMMARY ST                                                                                   | FATEMENT OF DEFICIENCIES                           | ID                         | PROVIDER'S PLAN OF CORRECTIO                   | N (X5)                        |  |  |  |  |
| PREFIX                                                                                            |                                                                                              | CY MUST BE PRECEDED BY FULL                        | PREFIX                     | (EACH CORRECTIVE ACTION SHOULD                 | BE COMPLETE                   |  |  |  |  |
| TAG                                                                                               | TAG REGULATORY OR LSC IDENTIFYING INFORMATION)                                               |                                                    |                            | CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | RIATE DATE                    |  |  |  |  |
|                                                                                                   |                                                                                              |                                                    |                            | 22.16.2.16.7                                   |                               |  |  |  |  |
| F 001                                                                                             | Continued From pag                                                                           | e 4                                                | F 001                      |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              |                                                    |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | ed she was newly hired at the                      |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | prior to the beginning of the                      |                            |                                                |                               |  |  |  |  |
|                                                                                                   | -                                                                                            | ector stated she was unable                        |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | ocumentation for the new                           |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | ctor confirmed the hire dates                      |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | cility staff members and                           |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | le to provide documentation                        |                            |                                                |                               |  |  |  |  |
|                                                                                                   | of a criminal backgro                                                                        | und check for those                                |                            |                                                |                               |  |  |  |  |
|                                                                                                   | employees.                                                                                   |                                                    |                            |                                                |                               |  |  |  |  |
|                                                                                                   | On 5/11/2022 the Fe                                                                          | ocility Administrator and                          |                            |                                                |                               |  |  |  |  |
|                                                                                                   | On 5/11/2023, the Facility Administrator and Corporate Nurse Consultant were informed of the |                                                    |                            |                                                |                               |  |  |  |  |
|                                                                                                   | ·                                                                                            | , "Criminal background                             |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | d to be obtained within 30                         |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | on is hired." The Corporate                        |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | gistered Nurses listed as                          |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | rough 19 were corporate                            |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | ne facility and the facility did                   |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | entation on them. The                              |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | nsultant stated there was                          |                            |                                                |                               |  |  |  |  |
|                                                                                                   | •                                                                                            | rate Office at the time of the                     |                            |                                                |                               |  |  |  |  |
|                                                                                                   | -                                                                                            | iew and interview to obtain                        |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | nel files. She stated that the                     |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | rere listed as employees                           |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | d a name badge in order to                         |                            |                                                |                               |  |  |  |  |
|                                                                                                   | work in the facility.                                                                        | a a name badge in order to                         |                            |                                                |                               |  |  |  |  |
|                                                                                                   | work in the lability.                                                                        |                                                    |                            |                                                |                               |  |  |  |  |
|                                                                                                   | No further information                                                                       | n was provided.                                    |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              |                                                    |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              |                                                    |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              |                                                    |                            |                                                |                               |  |  |  |  |
|                                                                                                   | 12VAC5-371-140(E)(                                                                           | (3)(a)                                             |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              |                                                    |                            |                                                |                               |  |  |  |  |
|                                                                                                   | Based on staff interv                                                                        | iew and facility                                   |                            |                                                |                               |  |  |  |  |
|                                                                                                   | documentation review, the facility staff failed to                                           |                                                    |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | n or professional license,                         |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | ect resident care for 11                           |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              | n a survey sample of 25 staff                      |                            |                                                |                               |  |  |  |  |
|                                                                                                   | members.                                                                                     | , , : : = : ::::                                   |                            |                                                |                               |  |  |  |  |
|                                                                                                   |                                                                                              |                                                    |                            |                                                |                               |  |  |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                            | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |                     |                                                                                                                  | (X3) DATE SURVEY<br>COMPLETED |                          |  |
|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------|--|
|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                            |                                         |                     |                                                                                                                  | С                             |                          |  |
|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | VA0264                     | E                                       | B. WING             |                                                                                                                  | 05/1                          | 1/2023                   |  |
| NAME OF P                                                                                            | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                            |                                         |                     |                                                                                                                  |                               |                          |  |
| WAVERLY                                                                                              | REHABILITATION AND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | HEALTHCARE CEN             | S E MAIN S<br>VERLY, V                  |                     |                                                                                                                  |                               |                          |  |
| (X4) ID<br>PREFIX<br>TAG                                                                             | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Y MUST BE PRECEDED BY FULL |                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |  |
| F 001                                                                                                | Continued From page 5 The findings included:  On 05/11/2023 at 9:30 a.m., a review of 25 employee records conducted with the Human Resources Director revealed there were issues with 11 records including the following:  A) Three (Staff #9, #10 and #11) of 7 CNA personnel records reviewed did not have certification verification and/or current certification prior to care.  B) Five Registered Nurses (#15, #16, #17, #18 and #19), 2 LPNs (#20 and #21), did not have license verification prior to care.  C) There was no license verification at the time of hire for 2 therapists (Staff #24 and #25), in a sample of 2 therapy staff within the 25 personnel records reviewed.  On 05/11/2023, the Facility Administrator was informed of the findings. She stated, "We obtain verifications for anyone who holds a professional license, to be sure they are qualified to provide the proper care to our residents and that their |                            | n                                       | F 001               |                                                                                                                  | RIATE                         | DATE                     |  |
|                                                                                                      | No further information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | n was provided.            |                                         |                     |                                                                                                                  |                               |                          |  |