State of Virginia

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		VA0100	B. WING		10/0) 4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	ATION CENTER	TH AIRPORT D D SPRINGS, V			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
F 000	Initial Comments		F 000			
F 001	Inspection was cond 10/04/2023. The fact with the Virginia Rule Licensure of Nursing were investigated du (VA00059688=Substa VA00059493=Substa VA00059202=Substa The census in this 12 115 at the time of the consisted of 48 residereviews.	ennial State Licensure ucted 09/25/2023 through cility was not in compliance es and Regulations for the if Facilities. Four complaints uring the survey. cantiated with Deficiency, cantiated with Deficiency, cantiated with Deficiency, cantiated with Deficiency). 20 licensed bed facility was es survey. The survey sample lent reviews and 25 staff	F 001			11/19/23
F 001		of compliance with the sure requirements:	F 001			11/19/23
	F553. 12VAC5-371-220 (HF580. 12VAC5-371-370 (AF584. 12VAC5-371-150 (AF600. 12VAC5-371-140 (AF607. 12VAC5-371-110 (BF607. 12VAC5-371-250 (BF637.	et as evidenced by: Please cross reference to Please cross reference Please cross reference Please cross reference		12VAC5-371-250 (I). Please cross reference to F553. 12VAC5-371-220 (H). Please cross reference to F580. 12VAC5-371-370 (A). Please cross reference to F584. 12VAC5-371-150 (A). Please cross reference to F600. 12VAC5-371-140 (A). Please cross reference to F607. 12VAC5-371-110 (B)(3). Please cross reference to F609 & F610. 12VAC5-371-250 (B)(2). Please cross reference F637. 12VAC5-371-250 (C). Please Cross Reference to F657.		

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

TITLE (X6) DATE

Electronically Signed 11/10/23

State of \	/irginia					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		VA0100	B. WING		C 10/04/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
LIENDICO	LICALTU O DELIADULITA	TION CENTER 561 NOR	TH AIRPORT D	RIVE		
HENRICO	HEALTH & REHABILITA	HIGHLAN	ID SPRINGS, V	A 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
F 001	Continued From page	e 1	F 001			
	12VAC5-371-220 (B). F658. 12VAC5-371-370 (A). F689. 12VAC5-371-220 (C). to F692. 12VAC5-371-220 (D). F695. 12VAC5-371-220 (A). F742. 12VAC5-371-300 (L). F755. 12VAC5-371-340 (A). F804. 12VAC5-371-340 (B). F809. 12VAC5-371-170 (B). to F867. 12VAC5-371-170 (B). to F867. 12VAC5-371-110 (J). F883. 12VAC5-371-110 (J). F883. 12VAC5-371-260 (B). to F949. 12VAC5-371-75 (B) (C). Based on staff intervidocumentation review obtain a sworn disclow #25) in a survey same	Please cross reference to Please Cross Reference to Please cross reference Please cross reference to Staff failed to sure for 1 employee (Staff		12VAC5-371-220 (B). Please cross reference to F658. 12VAC5-371-370 (A). Please Cross Reference to F689. 12VAC5-371-220 (C)(5). Please cross reference to F692. 12VAC5-371-220 (D). Please cross reference to F695. 12VAC5-371-220 (A). Please Cross Reference to F742. 12VAC5-371-270 (A). Please Cross Reference to F745. 12VAC5-371-300 (L). Please Cross Reference to F755. 12VAC5-371-340 (A). Please Cross Reference to F804. 12VAC5-371-340 (B). Please Cross Reference to F809. 12VAC5-371-170 (B)(2). Please cross reference to F867. 12VAC5-371-180 (A). Please Cross Reference to F883. 12VAC5-371-110 (J). Please cross reference to F883. 12VAC5-371-370 (E). Please Cross Reference to F925. 12VAC5-371-260 (B)(1). Please cross reference to F949. 12VAC5-371-75 (B) (1) 1. Staff #25, a sworn disclosure statement was obtained. 2. Current residents in the facility has the potential to be affected. An audit of sworn disclosure statements was	s s ave of	
	reviewed. For Staff #25, the fac	ility staff failed to obtain a		completed on current employees by the HR Director to verify completed. 3. The Administrator educated the H		

Director on the hiring process to include a

sworn disclosure statement.

sworn disclosure statement.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		_	
		VA0100	B. WING		C 10/04/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER	H AIRPORT DE			
		HIGHLAND	SPRINGS, VA	A 23075		
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F 001	Continued From page	2	F 001			
F 001	The findings included On 9/27/23 at approxinterview was conducted Resources Director (I statement has always of the hiring process, oath to do the right the The HRD verified that sworn disclosure on for the Prior to conclusion of provided the survey to titled, "Onboarding/Vi of 10/1/23, which was "The company will corregulations and guide employees who are established Commonwealth of Vi accurate personnel fi and in accordance with Administrative Code each new employees demographic and indemployment, as well Statement as require Virginia".	imately 1:00 PM, an sted with the Human HRD) who stated, "A sworn is been a very important part it's like a contract, taking an ing". It Staff #25 did not have a file. It he survey, the facility staff eam with a facility policy orginia", with an effective date is reviewed. This policy read, imply with all local and state estines as required for all employed in the orginia. 1. A complete and the, as outlined in Policy #207 th 12VAC5-371-140-E of the of Virginia, will be created for which contains the basic icative data needed for as: b. A sworn Disclosure icative data needed for as: b. A sworn Disclosure icative data needed for as: b. A sworn Disclosure icative data needed for as: b. A sworn Disclosure icative of Nursing were indings.	F 001	4. The Administrator or designee will conduct audits weekly x 4 then month 2 months on all new hires or rehires to ensure a sworn disclosure statement completed. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem not longer exist and sustained the review be conducted on a random basis. 5. Date of compliance: 11/19/2023 12VAC5-371-75 (B)(3) 1. Staff #4, #10, #13, #24 has not returned to the facility and were terme from the facility. 2. Current residents in the facility has the potential to be affected. An audit of criminal background checks was completed by the HR Director and Regional HR support on all current state had background checks Any staff providing direct patient care that did in have a criminal background check on was immediately removed from the schedule. 3. The Regional HR Director and Regional Director of Clinical Operation educated the Administrator, HR Director and Department Managers on the hiritoprocess, screening new and prior hire employees with review of prior employment and must have a Virginia State Police criminal background check returned, reviewed for barrier crimes in the employee work with direct resident.	dy x was pe e will d ve fall aff ot file scor ng s	
	12VAC5-371-75 (B)(3	3)		care. 4. The Administrator or designee will conduct audits weekly x 4 then month 2 months on all new hires or rehires to	ly x	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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IAG		,	IAG	DEFICIENCY)	
F 001	O	- 0	F 001		
F 001	Continued From page) 3	F 001		
				ensure the VA criminal background ch	ecks
	Based on staff intervie	ew and facility		are received prior to the onboarding	
	documentation review	v, the facility staff failed to		process and employee working. Resu	Its of
	obtain a criminal reco	ord report from the Virginia		the review will be presented to the QA	PI
	Department of State I	Police within 30 days of hire		committee for review and	
	for 4 employees, Staf	ff #4, #10, #13, and #24, in a		recommendation. Once the committee	;
	sample of 25 employe	ee records reviewed.		determines the problem no longer exis	st
				and sustained the review will be	
	The facility staff failed			conducted on a random basis.	
	background check wi	thin 30 days of hire for Staff		5. Date of compliance: 11/19/2023	
	#4, #10, #13, and #24	1.			
	The finalines in alcohol				
	The findings included			12VAC5-371-150 (G)	
	1 Staff #4 was hired	3/17/22 and terminated		12 VACS-37 1-130 (G)	
	employment on 10/1/2			1. The facility registered with the Vir	ninia
		nal background check had		Department of State Police to receive	9"""
		efore, from 3/17/22-10/1/22,		notice of the registration of any sex	
		ware of Staff #4's criminal		offender within the same or a contiguo	ous
	background status, a			zip code area in which the nursing fac	
	-	ent care during this time.		is located.	,
		one can be daming a me anno.		Current residents in the facility ha	ve
	2. Staff #10 was hired	d on 10/31/22 and		the potential to be affected.	
	***	ent on 1/10/23. There was no		3. The Administrator educated the	
		indicate that Staff #3 had a		admission team on the registered with	the
	· ·	check performed. Therefore,		Virginia Department of State Police to	
		3, facility staff were unaware		receive notice of the registration of an	
		I background status and was		sex offender within the same or a	
		direct care to Residents.		contiguous zip code area in which the	
				nursing facility is located and to retain	
	3. Staff #13 was hired	d 7/5/22 and terminated		record of the alerts received.	
	employment on 10/8/	22. Staff #13's had no		4. The Administrator or designee wil	I
	criminal background	check on file. Therefore,		conduct audits weekly x 4 then month	ly x
	from 7/5/22-10/8/22, f	facility staff were unaware of		2 months to verify any notices receive	d
	Staff #13's criminal ba	ackground status and was		regarding sex offenders were retained	
	permitted to provide of	direct care to Residents.		Results of the review will be presented	d to
				the QAPI committee for review and	
	4. Staff #24 was hired	d 3/8/23. Staff #24's criminal		recommendation. Once the committee	;
	background check wa	as requested on 3/7/23 and		determines the problem no longer exis	st
	noted to read, "transa	action is being processed"		and sustained the review will be	

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	LTIPLE CONSTRUCTION (X3) DATE SURVE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	ILDING: COMPLET	
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		VA0100	B. WING	10/04/202	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE	
			TH AIRPORT D	,	
HENRICO	HEALTH & REHABILITA	TION CENTER	ID SPRINGS, V		
0(1) 15	STIMMADA ST	ATEMENT OF DEFICIENCIES			J (7/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
F 001	Continued From page	e 4	F 001		
	and the final report w	as not on file. Therefore,		conducted on a random basis	
		time of survey, the facility		5. Date of compliance: 11/19/2023	
	staff were unaware of				
	background status ar			12VAC5-371-210 (E)	
		to work without knowing if			
	the employee was gu	ilty of a barrier crime.		1. Staff #4, #5, #8, #9 ,#10 are no lo employed by the facility , Staff #6, #7	
	On 9/27/23 at approx	imately 1:00 PM. an		license and certifications are active .	,,,_,
	interview was conduc			2. Current residents in the facility ha	ive
		HRD) who stated, "We get		the potential to be affected. An audit to	
	criminal background	checks on every applicant.		the HR Director to verify all current sta	aff
	For the Virginia State	Police, we wait 30 days,		with licensed or certification are active	; .
	-	th another employee while		3. The Administrator educated HR	
	we wait for it".			director on ensuring staff that are licer	
				or certified have an active license and	
		t Staff #4, #10, #13, and #24		review of any additional information of	
		al background report within		license to determine if able to proceed	
	30 days of their respe	ective nire dates.		with hiring process. Licensed and cert cannot work until license and certifications	
	A review of the facility	's policy optitled		is verified to protect residents.	JOH
	"Abuse/Neglect/Misa			The Administrator or designee will	ıı
		g/Training", dated 1/23/20,		conduct audits weekly x 4 then month	
		item 1 read, "Criminal		2 months on all staff to verify staff with	
		ence checks are performed		license and certifications are active.	
	on all employees".	·		Results of the review will be presented	d to
				the QAPI committee for review and	
	Prior to conclusion of	the survey, the facility staff		recommendation. Once the committee	;
		eam with a facility policy		determines the problem no longer exis	st
		rginia", with an effective date		and sustained the review will be	
	· ·	s reviewed. This policy read,		conducted on a random basis.	
		mply with all local and state		5. Date of compliance: 11/19/2023	
	, ,	elines as required for all		40) (4.05, 0.74, 0.40, (5) (4)	
	employees who are e			12VAC5-371-210 (F)(1)	
		rginia. 1. A complete and		1. Staff #11, #13 #14 are no longer	
	-	le, as outlined in Policy #207 th 12VAC5-371-140-E of the		employed by the facility.	N/O
		of Virginia, will be created for		2. Current residents in the facility had the potential to be affected. An audit to	
		which contains the basic		the HR Director to verify all current sta	-
		icative data needed for		with licensed or certification are active	
		as: a. A criminal history		3. The Administrator educated the H	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE : COMPL		
		VA0100	B. WING		C 10/04/2023
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	56	REET ADDRESS, CITY		·
		HI	GHLAND SPRING	S, VA 23075	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETE DATE DATE
F 001	Continued From page	: 5	F 001		
	conducted via Virginia Justice Interface (NC 32.1-126.01 of the Co On 9/27/23, the Facili	ode of Virginia". ty's Administrative pirector of Nursing were		Director on the process for staff with licensed and cerenewed and active to prowule to the staff member cannot or certification is expired a renewed. 4. The Administrator or conduct audits weekly x 4 2 months on all staff to verification or the staff to verification.	rtification are otect residents t work if license and termed if not designee will then monthly x
	No additional information was provided.			license and certifications Results of the review will the QAPI committee for re	be presented to
	12VAC5-371-150 (G)			recommendation. Once the determines the problem n	
	register with the Virging Police to receive notice re-registration of any	 the facility staff failed to nia Department of State ce of the registration or sex offender within the zip code area in which the 	9	and sustained the review conducted on a random b 5. Date of compliance:	will be asis.
	The findings included	:			
	interview was conducted Director of Nursing (EC) Consultant (RNC) to consultant (RNC) to consultant (VSP) to receive notifications.	imately 1:15 PM, a group ted with Employee E, the iON), and Regional Nurse determine the facility's in the Virginia State Police ications of registered sex local area. The RNC stated will look into it".	,		
	E stated, "This facility receive sex offender i Police but we were all afternoon to begin rec	notifications from the State ble to register yesterday ceiving the notifications". a copy of the facility's			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,		CONSTRUCTION	(X3) DATE S COMPLI	
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		VA0100	B. WING		ı	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER	I AIRPORT DR SPRINGS, VA			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETE DATE
F 001	Continued From page	e 6	F 001			
	offender notifications Police effective 9/25/2	from the Virginia State 23 at 3:38 PM.				
	was updated on the fi	imately 5:30 PM, the RNC ndings at the end of day er information was provided.				
	12VAC5-371-210 (E)					
	verify the professional licensed professional Staff #6, Staff #7, Sta and Staff #21, in a sa	v, the facility staff failed to I nursing license for 8 nurses, Staff #4, Staff #5, ff #8, Staff #9, Staff #10,				
	nursing license was a with the State Licensi Staff #4, Staff #5, Sta	I to verify the professional active and in good standing ng Board for Nurses for ff #6, Staff #7, Staff #8, Staff aff #21, prior to allowing t resident care.				
	The findings included	:				
	On 9/27/23, a review records was conducted following:	of staff nursing personnel ed and revealed the				
	on 10/1/22. Staff #4's verified until 5/11/22. through 5/11/22, facili #4 was an active, reg standing with the Staff	on 3/17/22 and terminated nursing license was not Therefore, from 3/17/22 sty staff was unaware if Staff istered nurse and in good the Licensing Board. Staff #4 wide direct care to Residents.				

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 561 NORTH AIRPORT DRIVE HICHLAND SPRINGS, VA. 23075 VAJ. D PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE AIRTORS HOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) FOUL COntinued From page 7 F 001	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
HENRICO HEALTH & REHABILITATION CENTER (XA) ID SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 001 Continued From page 7 2. Staff #5 was hired on 10/7/21 and remained an active employee at the time of survey. There was no professional license verification conducted until 11/30/21. Therefore, from 10/7/21 through 11/30/21, facility staff were unaware if Staff #5 was an active, registered nurse and in good standing with the State Licensing Board. Staff #5 was permitted to provide direct care to Residents. 3. Staff #6 was hired on 7/17/23 and remained an active employee at the time of inspection/survey. Staff #6s professional license verification was dated 7/20/23. Therefore, Staff #6 was hired and employed as a Registered Nurse, without the facility knowing if he/she held a current and active nursing license. 4. Staff #7 was hired on 10/3/22. Staff #7's professional nursing license verification was dated 11/1/22. Therefore, from 10/3/22 through 11/1/22, facility staff was unaware if Staff #7's nursing license was an active, and in good standing with the State Licensing Board, during that time. 5. Staff #8 was hired on 7/11/22 and terminated employment on 3/30/23. There was a employee a terminated employment on 3/30/23. There was a			VA0100	B. WING			_
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFY PREFIX TAG REGULATO			TION CENTER 561 No	ORTH AIRPORT DE	RIVE		
2. Staff #5 was hired on 10/7/21 and remained an active employee at the time of survey. There was no professional license verification conducted until 11/30/21, Therefore, from 10/7/21 through 11/30/21, facility staff were unaware if Staff #5 was an active, registered nurse and in good standing with the State Licensing Board. Staff #5 was permitted to provide direct care to Residents. 3. Staff #6 was hired on 7/17/23 and remained an active employee at the time of inspection/survey. Staff #6's professional license verification was dated 7/20/23. Therefore, Staff #6 was hired and employed as a Registered Nurse, without the facility knowing if he/she held a current and active nursing license. 4. Staff #7 was hired on 10/3/22. Staff #7's professional nursing license verification was dated 11/1/22. Therefore, from 10/3/22 through 11/1/22, facility staff was unaware if Staff #7's nursing license was an active, and in good standing with the State Licensing Board, during that time. 5. Staff #8 was hired on 7/11/22 and terminated employment on 3/30/23. There was a	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
professional license verification conducted 7/8/22, which indicated there was additional information available, against the employee's nursing license. The facility staff failed to look up the additional information to determine what actions had been taken against the license to determine if this was an applicant they wanted to employ. 6. Staff #9 was hired on 11/14/22 and terminated employment on 1/28/23. There was no professional license verification conducted until 9/27/23. Therefore, throughout the duration of Staff #9's employment, facility staff were unaware	F 001	2. Staff #5 was hired active employee at th no professional licens until 11/30/21. There 11/30/21, facility staff was an active, registe standing with the Stat was permitted to prov 3. Staff #6 was hired active employee at th Staff #6's professional dated 7/20/23. Theref employed as a Regist facility knowing if he/s nursing license. 4. Staff #7 was hired professional nursing I dated 11/1/22. Theref 11/1/22, facility staff wnursing license was a standing with the Staff that time. 5. Staff #8 was hired employment on 3/30/2 professional license which indicated there available, against the The facility staff failed information to determ taken against the lice an applicant they war 6. Staff #9 was hired employment on 1/28/2 professional license w 9/27/23. Therefore, ti	on 10/7/21 and remained an e time of survey. There was se verification conducted fore, from 10/7/21 through were unaware if Staff #5 and nurse and in good se Licensing Board. Staff #5 and direct care to Residents. on 7/17/23 and remained an e time of inspection/survey. Il license verification was fore, Staff #6 was hired and stered Nurse, without the she held a current and active on 10/3/22. Staff #7's incense verification was fore, from 10/3/22 through was unaware if Staff #7's in active, and in good se Licensing Board, during on 7/11/22 and terminated 23. There was a rerification conducted 7/8/22, was additional information employee's nursing license. It to look up the additional ine what actions had been nose to determine if this was atted to employ.	F 001			

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HENRICO	HEALTH & REHABILITA	TION CENTER	H AIRPORT DE D SPRINGS, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
	restrictions to practice nurse, and if the licer with the State Licens permitted to provide of 7. Staff #10 was hired terminated employmed license was checked there was additional in the state of the	ent on 1/10/23. The nursing on 10/26/22 and indicated information on the license.				
	the additional informathreat to the Residen 8. Staff #21 was hired a licensed practical into verify that Staff #2 nursing license until 7 permitted to work in the 6/20/23-7/17/23, with he/she held an active On 9/27/23, an intervhuman resources manaked about checking license, the HR manaimportant to do, if you can't hire you in those verified the above find information to provide On 9/27/23, the Facil Representative and Expresentative and Exprese	iew was conducted with the nager/Employee F. When g a person's professional ager said, "That is very u don't have a license, we e positions". The HRD dings and had no further e.				
	information was provi	ided.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMP	SURVEY	
		VA0100	B. WING		l l	C /04/2023
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	TION CENTER 561 NC	ADDRESS, CITY, STA	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 001	verify the certification members, Staff #11, #5 certified staff emploon. The facility staff failed certification as a nurs standing with the Staff Staff #11, #13, and #7 provide direct residen. The findings included. On 9/27/23, a review was conducted. The 1. Staff #11 was hired employment on 2/4/25 Staff #11's did not incented their certification as a verified with the board Staff #11 was permitted providing direct Residual staff knowing if they hunencumbered certification on 10/8/2 of Staff #13's employed assistant (CNA), the find the employee helicertification to practical staff #14, who terminated on 3/20/23 the employee to work	ew and facility the facility staff failed to for 3 certified staff tata, and #14, in a sample of yee records reviewed. to verify that the ing assistant was in good e Certification Board for 4 prior to allowing them to t care. of the sampled staff records following was noted: on 4/4/22 and terminated a. The employee file for lude any verification that nursing assistant was for nursing. Therefore, ed to work for 10 months, ent care, without the facility eld an active and cation to practice/work in on 7/5/22 and terminated cation to practice/work in	F 001			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		VA0100	B. WING		C 10/04/2023
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA		10/04/2023
HENRICO	HEALTH & REHABILITA	HON CENTER	HAIRPORT DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
F 001	Continued From page	e 10	F 001		
	unencumbered certific 8/10/22.	cation as a CNA until			
		iew was conducted with the rector (HRD) who confirmed			
	Facility's Administrativ	n end of day meeting, the ve Representative and ere made aware of the			
	No further information	n was provided.			