STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40026 Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure the Resident's right to a dignified existence for 2 Residents (#'s 269 & 90) in a survey sample of 60 Residents. For Resident #269 the facility staff failed to ensure the Resident's right to dignity and privacy by using his photo and diagnoses on a marketing flyer that they posted in the elevator. On 9/12/22 at approximately 2:00 PM Surveyor D observed a marketing flyer in the elevator that read: [Company name and logo redacted] Celebrating Success We are pleased to share another wonderful rehab success story from: [Address and phone number of facility redacted [Resident #269 name redacted] came to [Facility name redacted] from [hospital name redacted]. [Resident #269 name redacted] experienced a fall at home due to a Urinary Tract Infection, luckily no injuries sustained from the fall. [Resident #269 name redacted] had difficulty with walking and performing steps so he could return home. [Resident #269 name redacted] required help with his bathing, dressing, and toileting. [Resident # 269 name redacted] family was very supportive and very involved with his care. While at [facility name redacted], [Resident # 269's name redacted] made significant gains with his therapy plan of care, he was able to increase his walking abilities to over 350 ft., and was able to successfully navigate steps with no increased pain or assistance. [Resident #269 name redacted] was able to bathe, dress, and complete his toileting with little to no assistance. Name: [redacted] Admitting Diagnosis: UTI with a fall LOS: [length of stay] 34 days (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Discharge Location: Home [There was a graph on the page that showed his Functional Outcome Measures from Admission to Discharge for Bathing, Bed mobility, Grooming, Toileting, Upper body Dressing, Lower Body Dressing, Gait, Stairs, Transfers.] On 9/12/22 during the end of day meeting Surveyor D requested that the Administrator show documentation that Resident #269 approved or gave consent to disclose his protected health information (diagnosis of UTI and fall) that was used in the marketing flyer posted in the elevator, Surveyor D requested again on 9/13/22 and was told that the Administrator was awaiting for regional manager to get back to him. On 9/15/22 at 1:02 PM an interview was conducted with the Administrator and Employee D (the Regional Nurse Consultant) On 9/16/22 when the Admission package was reviewed it was found that the resident signed giving to use his photo however nothing was mentioned about using his protected health information along with his photo. The Administrator and Employee D (Regional Nurse Consultant) were both asked about permission to use his diagnosis and both stated that all they have is what is in the contract. On 9/16/22 a review of the facility's HIPAA policy read as follows: 1 - To respect the privacy and confidentiality of any information you may have access to through our computer system or network and that you will access or use only that information necessary to perform your job. 3 - To disclose confidential resident, business, financial or employee information ONLY to those authorized to receive it. 7 - Not to release or disclose the contents of a resident or facility record except to fulfill your work. On 9/16/22 an excerpt of the facility's Routine Resident Care Policy read: h. Maintains confidentiality of resident information at all times including but not limited to: i. photographs . ii. social media . iii. unauthorized email, fax, texting or telephone communication . iv. unauthorized communication in inappropriate environments such as open hallways, within the immediate vicinity of other residents/family or outside of the facility. On 9/16/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #90, the facility staff failed to maintain dignity and assist Resident #90 getting cleaned after her meal, resulting in Resident #90 sitting up in bed sleeping in front of her meal tray with a soiled clothing protector in place on 09/13/2022. 40452 On 09/13/2022 at 9:30 A.M., Resident #90 was observed asleep in her bed with the head of the bed elevated approximately 60 degrees. Resident #90 had a plaid clothing protector on with food particles on it. The tray table with the breakfast tray was positioned over the bed and in front of Resident #90. All the food had been eaten off the plate. There was no staff in the room. At 9:36 A.M., Certified Nursing Assistant N (CNA N) entered Resident #90's room, took the tray off the tray table, exited the room, and placed the tray on the cart in the hall. CNA N then re-entered Resident #90's room, walked past Resident #90, and took the roommate's tray to the cart in the hall. CNA N then proceeded to the adjacent room and removed those breakfast trays. At 9:50 A.M., Resident #90 was observed still sleeping with the head of the bed elevated approximately 60 degrees, and the plaid clothing protector on with food particles on it. At 10:00 A.M., CNA N was interviewed. When asked about the process of assisting a Resident after mealtime, CNA N stated that afterwards, she would assist the resident to clean their face, hands, and mouth. When asked why Resident #90 still had a clothing protector on, CNA N stated that she should have taken it off after the meal. When asked why, CNA N stated it's for dignity and make sure she's clean. CNA N then entered Resident #90's room, observed Resident #90 with the clothing protector on, and left the room and headed down the hall stating she was going to get help so Resident #90 could be toileted. CNA N did not remove the clothing protector at that time. On 09/14/2022, Resident #90's clinical record was reviewed. Resident #90's quarterly Minimum Data Set with an Assessment Reference Date of 08/23/2022 coded the functional status for eating as requiring extensive assistance from staff. The Brief Interview for Mental Status was coded as 3 out of 15 indicative of severe cognitive impairment. The care plan was reviewed. There was not a focus, goals, or interventions on the care plan associated with Activities of Daily Living. On 09/13/2022 at approximately 5:30 P.M., the Administrator and Director of Nursing (DON) were notified of findings. When asked about the expectation, the DON stated that if a resident is assisted with eating, the staff should clean up the resident and make sure they are comfortable The DON then stated she would retrain the staff on the topic of resident dignity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 41449 Based on observation, resident interview, staff interviews, facility documentation review and clinical record review, the facility staff failed to assess and determine if a Resident was safe to self-administer medications, for one Resident (Resident #35) in a survey sample of 60 Residents. The findings included: For Resident #35, who had medications stored in his room, the facility staff failed to assess if Resident #35 was safe to self-administer medications and removed the medications, stating it was not permitted. On 9/13/22 at 9:28 PM, Resident #35 was observed awake and sitting on the edge of his bed. A Resident interview was conducted and during this interview Resident #35 was observed with a bottle of Tums/antacid tablets on his bed and in the bottom of his bed side table several prescription bottles were observed. On 9/13/22 at 9:31 PM, an interview was conducted with LPN D. When asked if she has any Residents that self-administer medications and are permitted to keep them in their room, she said, No, we have to keep all medications in the medication cart, we don't allow them to keep any in their rooms. On 9/14/22 at 9:30 AM, Resident #35 was visited in his room. Resident #35 showed Surveyor B that he had a bottle of Tums, bottle of Tylenol, 2 pill bottles that the label was worn on and the contents were unable to be identified. Resident #35 reported that one bottle had anti-diarrhea medication and the other was Tylenol. There was a box of refresh eye drops. Resident #35 reported, They confiscated them for a while but then put it on their list and said I could keep them, referring to the eye drops. On 9/15/22 at 4 PM, during an interview with Resident #35, the Resident said, Someone came and took my medicines, they got gone yesterday. He continued, The refresh plus is for my eyes and the Tylenol is for my aching back versus going to the nurse and waiting forever to get it. My wife called the police because they were stolen. The question is who took them and second, were they destroyed. They are over the counter medicines and I would like them back. On 9/15/22 at 5 PM, an interview was conducted with LPN J, the Unit Manager for the second floor. When asked about Resident #35's medications, LPN J said, When I made my rounds yesterday I saw medications under his pillow and in the drawer, they were eye drops and Tums, I called the wife and explained he is not allowed to keep medications in his room. We have scheduled the eye drops every 12 hours and the Tums is every 4 hours as needed, we will use his supply. When asked why he is not permitted to keep them in his room she said, It is not safe. When asked if Residents are able to self-medicate, LPN J said, No, we don't allow that here. On 9/15/22 at 5:25 PM, during the end of day meeting, the facility Director of Nursing (DON) was asked if they have any Resident who self-administer medications. The DON said, No, we don't have any Residents that self-administer medications. When asked if this is permitted, the DON said, I will check. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/14/22 and on 9/15/22, the facility staff were asked to provide a self-administration of medication assessment for Resident #35. This was never received prior to the survey team's exit. Review of Resident #35's entire clinical record, to include but not limited to: physician orders, care plan, nursing notes, assessments, and interdisciplinary team meeting notes there was no indication that Resident #35 had been assessed for his ability to self-administer medications. On 9/21/22, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware that Resident #35 was not assessed for, nor afforded the opportunity to self-administer medications. A review was conducted of the facility policy titled, Resident Self-Administration of Medications. This policy read, It is the policy of this facility to provide resident centered care that safeguards the Resident's right for self-administration of their own medication that supports resident dignity and self-determination . The facility will periodically review the ability to self-administer medication based upon change in status .On admission, the facility will assess the resident for safety through the IDT (Interdisciplinary Team) care planning team prior to the resident exercising their right of self-administration of drugs within 7 days after the comprehensive assessment is completed as required by regulations . The policy continued to read, Procedure: 1. Determine if the resident desires to self-administer their own medication. a. Resident may not self-administer medication until the assessment is completed by the IDT team and determined safe to do so .2. Resident may self-administer some or all of their medications . No further information was provided. 31199

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 40026 Based on observation, interview, facility record review and clinical record review the facility staff failed to ensure the right of self-determination for 1 Resident (#31) in a survey sample of 60 Residents. The findings included: For Resident #31, the Resident had made it clear to staff she wanted only female CNA's to work with her, as evidenced by the care plan entry dated 6/10/22, however, they continued to schedule male CNA's to be assigned to her. On 9/21/22 at approximately 10:30 AM an interview was conducted with Resident #31 who stated, I don't want none of those men undressing me. Resident #31 stated, I told him No and he got angry and banged his fist on the table it was threatening. I was afraid he would come back. On 9/20/21 an interview with the DON was conducted and she was informed of the Resident's complaint she stated she was aware and they had addressed it in the care plan meeting in June. When told that the Resident stated it had happened a few days ago, the DON stated that Resident #31 has dementia and is confused about the time. A review of the Concern Forms (grievance log) revealed that on June Social worker had filled out a Concern Form for Resident #31 that read: [Resident #31 name redacted] reported that her CNA [CNA Q name redacted] is rough during ADL's and keeps washing and washing her and it is rough on her skin. Resident requested to have female CNA's who are gentle her the skin. Attached to the concern form was a sign off sheet where CNA Q was provided education and signed off. On 9/21/22 a review of the care plan revealed that on 6/10/22 during the care plan meeting this topic was addressed and the care plan read: FOCUS- [Resident #31 name redacted] is at risk for Self Care Performance deficit and requires assistance with ADL care GOAL- 06/10/2022- resident requested to have a female CNA perform her ADL's. Resident will maintain current level of function. INTERVENTION- Female CNA to perform ADL's care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16 a review of the clinical record revealed that Resident #31 had male CNA's signing off on the POC (Point of Care) system the Resident had continued to have male CNA's as recently as 9/18/22 and 9/19/22. On 9/16/22 the DON was asked about Resident #31 having male CNA's she stated that they had a care plan meeting and updated the care plan for no male CNA's. When asked why this was done she stated the Resident does not want male CNA's, and it's her right to have this choice On 9/17/22 the Administrator was made aware of the concerns and no further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 41449 Based on Resident interview, staff interviews and facility documentation review, the facility staff failed to permit Residents to access their personal funds/trust accounts on weekends and evenings, for Residents with trust accounts. The findings included: On 9/13/22 at 10:20 AM, an interview was conducted with the receptionist/Employee G. Employee G confirmed that a staff member is at the receptionist desk from 7 AM until 8 PM, Monday through Friday and on weekends from 8 AM until 8 PM. On 9/15/22, Resident #2 was interviewed regarding his access to his trust account. Resident #2 said he had to go downstairs to the business office to make withdrawals and they are only open Monday-Friday. On 9/19/22 at 3:15 PM, an interview was held with Employees CC/the assistant regional director of finance and Employee J, the divisional director of revenue cycle. They reported, We have banking hours. On 9/19/22 at 4:40 PM, an interview was conducted with Employee G/the receptionist. Employee G was asked how Residents access or withdraw money from their trust account. Employee G said, They go to the business office. When asked what they do on the weekends when the business office is closed, Employee G said, They would have to call him [referring to the business office manager]. On 9/19/22 at 4:43 PM, CNA J was asked how Residents access their money. CNA J said, They go to the social worker. On 9/19/22 at 4:45 PM, an interview was conducted with Employee E, the social worker. The social worker was asked how Residents access their trust account. Employee E said, They come to the business office. When asked what happens on weekends, Employee E said, I don't know the process, I haven't had anyone complain that they didn't have access on weekends. On 9/19/22 at 5:10 PM, an interview was conducted with Resident #88, the Resident Council President. When asked how Residents access their money, Resident #88 said, They have to go to the business office. The Resident confirmed that the business office is open Monday through Friday. When asked if someone wants money on the weekends, what they do, Resident #88 said he was not aware and suggested I talk with Resident #70. On 9/19/22 at approximately 5:20 PM, an interview was conducted with Resident #70. When asked about accessing money from his trust account, Resident #70 said that he has to go to the business office during their work hours to access his money or make withdrawals. When asked what happens if it is a weekend, Resident #70 said, You are out of luck. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/22 at 5:27 PM, an interview was conducted with Employee DD, the admissions director. When asked, how do Residents withdraw money from their trust account? Employee DD said, They go to the business office. When asked what happens when the business office isn't here, she said, They have [Employee J's name redacted] who comes and they let [Administrator's name redacted] know. When asked about accessing funds on weekends, Employee DD said, On weekends it should be activities that assists with that. On 9/19/22 at 5:30 PM, an interview was conducted with Employee EE, the activity leader. Employee EE was asked how Resident's get money from their bank/trust account, Employee EE said, They go through the business office. On 9/20/22 at 2:40 PM, an interview was conducted with the facility Administrator. The Administrator was asked how Residents access money from their trust account and he said, After hours they come to the reception desk to get money. Following the response from the Administrator, Employee G, the receptionist was again asked if she has funds available to distribute to Residents. Employee G said, I was just told about this process and confirmed that this will be a new process implemented and that currently she has no funds available to distribute. The facility policy titled, Resident Trust Fund, was reviewed. The policy did not address when Residents can access money from their trust fund. During the survey there were two days the survey team observed that the business office was closed and no staff were able. The facility Administrator confirmed no one was available in-house on those days and someone from Corporate would be coming the following day. On 9/21/22, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware that Residents do not have access to their funds when the business office is closed. No additional information was available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 41449 Based on Resident interview, staff interview, and facility documentation review, the facility staff failed to provide Residents with quarterly statements of their trust account/bank accounts effecting 4 Residents (Resident #2, 20, 91, and 70) in a survey sample of 60 Residents. The findings included: On 9/15/22, an interview was conducted with Resident #20. Resident #20 was asked if he gets statements quarterly as to how much money is in his trust account. Resident #20 said, No, I don't get statements and I would like to know how much is in there. On 9/15/22, Resident #2 was interviewed regarding trust statements. Resident #2 said he doesn't receive any statements from the facility. On 9/19/22, Resident #70 was interviewed and stated he doesn't receive trust statements and would like to know how much is in his account. On 9/19/22 at 3:15 PM, Surveyor B went to the business office and asked to see evidence of trust statements for the last 3 quarters. Employee J, the Regional Director of Revenue Cycle said she had discovered that there was no evidence that the statements from June 2022, had been delivered to Residents so she gave them to the Administrator on 9/16/22, to deliver to Residents. Employee J said the facility protocol is for the Residents to sign the statements to provide evidence that they received the statement. Employee J was asked if the Residents are then given a copy to keep for themselves and she was not sure. Employee J stated she had no evidence that the Residents were provided the statements on a quarterly basis. Trust statements for December 2021, March 2022, and June 2022, were received and reviewed. The statements for December 2021 and March 2022 had no indication that the Residents received a copy. The March 2022, statements had a form RFMS Quarterly Statement Certification for Proof of Mailing that was not filled out and was blank. The trust statements for June 2022, were signed by Residents #2, 91 and 20 on 9/16/22. The clinical record for Residents ##2, 20, 91, and 70, was reviewed. There was no evidence that the Residents had received trust account statements documented within the clinical record. A review of the facility policy titled, Resident Trust Fund was conducted. This policy read, .9. Quarterly Statement of Account. A quarterly accounting of the funds managed by the facility is provided to each resident or their legal representative per State guidelines. Quarterly statements are received from RFMS (Resident Fund Management System) by the Business Office and then reviewed and approved by the Executive Director and provided to the resident or mailed to the resident's legal representative not later than the 20th of the month following the end of each quarter. In addition, the Executive Director is to sign the Certification of Mailing as proof that the statements were mailed. Copies of the statements provided or mailed and the Certification of Mailing are to be filed in the resident trust fund monthly file of the last month in each quarter . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/22, the facility Administrator was made aware of the above findings. No additional information was received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on staff interview, family interview, clinical record review and during the course of a complaint investigation, the facility staff failed to provide one resident (Resident # 217) with a conveyance of funds within 30 days. Findings included: For Resident # 217, the facility staff did not convey funds within 30 days. Resident # 217 was admitted to the facility on [DATE] and transferred to the hospital on [DATE]. Resident # 217 did not return to the facility. Review of the Personal Funds account for Resident # 217 revealed documentation that the account was not reconciled until [DATE]. Resident # 217 transferred from the facility on [DATE]. A check was written on [DATE] but was not cashed. An audit in [DATE] revealed the check had not been cashed. The facility staff voided the check and wrote another check in [DATE]. The final check was written on [DATE] and cashed on [DATE]. On [DATE] at 2 p.m., an interview was conducted with the Regional Business Office Consultant (Employee J) who stated that the facility staff should reconcile the accounts within 30 days once we [the facility] receives all payments due. Regarding the Trust Funds, Employee J stated once discharges or the resident expires, then it is 30 days after discharges or expiration, assuming they are not returning. Employee J was asked to review Resident # 217's fund accounts to determine the date the account was reconciled. Employee J stated according to the documentation, the resident expired on [DATE]. There was a check written on [DATE] to close the account. The check number was # 1071 for the amount of $1549.56. The check # 1071 was voided and reissued on [DATE] as check # 1076 for the amount of $ 1549.56. Employee J stated the she actually audited this account in May. The National Data Care System was set up that checks could be left open indefinitely. Employee J stated the issue was that the check # 1071 was not cashed originally. When I came in May, I audited records and found the check not cashed, another check was written after voiding the first check. Review of the Patient Funds account and Trust Funds account revealed lack of sufficient evidence of funds being misappropriated. However, the facility staff failed to reconcile the account timely within 30 days as per the regulation and facility policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the end of day debriefing on [DATE], the facility Administrator, Director of Nursing and Corporate Consultants were informed of the findings that for Resident # 217, the facility staff failed to reconcile the account timely. The Corporate Consultant stated the funds should have been rectified within 30 days. No further information was provided. COMPLAINT DEFICIENCY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. 41449 Based on Resident interview, staff interviews and facility documentation review, the facility staff failed to only withdraw funds authorized for the cost of care for one Resident (Resident #70) in a sample of 3 Residents reviewed for trust fund transactions. The findings included: For Resident #70, the facility withdrew funds monthly in excess of what was due to the facility for the Resident's cost of care as directed by Medicaid. On 9/19/22, Resident #70 disclosed during an interview concerns about money received not being deposited into his bank account/trust fund. On 9/19/22, Surveyor B asked for a transaction history of Resident #70's account and the patient liability (amount Resident is responsible to pay towards cost of care when on Medicaid) from the Virginia Medicaid web portal. The requested items were received and reviewed. The findings were as follows: 1. August 2021-September 2022, Medicaid indicated that Resident #70 was responsible to pay $838.00 per month as his patient liability. 2. For the months of August, September, October, November, and December 2021, the facility deducted $849.00 from the trust account monthly, which was an overpayment of $11 per month. This totaled an overpayment of $55 for the year of 2021. 3. For the months of January-September 2022, the facility withdrew $901 per month to apply towards cost of care. This was a monthly overpayment of $52 per month, which equaled a total overpayment in 2022 of $468. On 9/20/22, an interview was conducted with Employee J, the Regional Director of Revenue Cycle who was present in the absence of the facility business office manager. Employee J was asked if she had any significant findings from the review of the documents Surveyor B had requested for Resident #70. Employee J said, yes, she had identified that they were deducting the wrong amount from Resident #70's account for the cost of care and was not certain why this had been done. Review of the facility policy titled, Resident Trust Fund was conducted. This policy read, Purpose: To hold, safeguard, manage, control and reconcile the personal needs funds deposited with the facility by residents, as authorized, in a manner and in compliance with all laws and regulations to provide the residents with accurate and timely information regarding their personal funds . On 9/21/22, the facility Administrator was made aware of the above findings. No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 31199 Based on observation, and staff interview, the facility staff failed to provide required postings, including a list of names, addresses, and telephone numbers for State Agencies, and advocacy groups, which are mandated by regulation to be accessible and understandable for the resident population. The findings included; During the surveyor's initial tour of the facility on 9-12-22 observations included all resident rooms and common areas of the two floors where residents resided in the building. No posting which listed the required names, addresses, and telephone numbers for State Agencies and advocacy groups which are accessible, and understandable to residents, could be found. The Social worker was asked where the posting could be found, and she stated it had been posted by the elevators, but was taken down during renovations, and it had not been replaced. When asked how long ago that happened, she stated she could not remember, and further stated it was awhile ago. On 9-13-22 the LPN unit Manager was asked about the posting, and she stated they were going to replace it. On 9-14-22 during Resident Council meeting, all of the Residents in attendance stated they had no idea how to contact advocacy organizations if they were fearful of abuse, or had a grievance or complaint about their care, and had no idea how to find the information. On 9-22-22 at the time of survey exit, the posting had still not been replaced. The Administration was made aware of the findings and had nothing further to add.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 41449 Based on observation, Resident interview, and staff interview, the facility failed to post survey results in a place readily accessible to Residents and families, which had the potential to affect all 119 Residents residing in the facility. The findings included: On 09/13/22 at 11:00 AM, a resident Council meeting was conducted. When the group of Residents were asked if they knew where the survey results were located, all of the residents in the meeting indicated they did not know where the survey results were located. On 09/13/2022, Surveyor B toured the entire facility looking for the previous survey results, they were unable to be located. On 9/13/22 at 8:43 AM, the receptionist/Employee G, was asked where the survey results from prior surveys are located. Employee G said, They are normally kept right out in the open, they used to be on a table as you entered station 1, since they renovated I am not sure, let me ask. Employee G found a binder at the receptionist desk, located in the lobby, but noted that the binder was empty. Employee C then entered the lobby and when Employee G asked her about it, she said the Administrator had it. The facility Administrator was asked where the survey results are located. The facility Administrator went to his office and pulled a binder that included the plan of correction for the most recent survey. Surveyor B explained she was looking for the prior survey results/reports that are accessible to Residents and families. The Administrator and Surveyor B then to the nursing station on the first floor and they were unable to be located. On 9/13/22 at 9:10 AM, the facility Administrator approached Surveyor B and had a binder with survey results and said, It was at the reception desk. On 9/13/22 at 10:20 AM, a follow-up interview was conducted with Employee G/the receptionist. Employee G stated she had overlooked the book with survey results previously when she looked. Employee G confirmed the receptionist desk is staffed from 7 AM until 8 PM, Monday through Friday. On the weekends it is staffed from 8 AM until 8 PM. On 9/15/22, upon the survey teams entry to the facility it was observed that a sign had been posted on the lobby side of the door between the lobby and Resident care unit, that read, [facility name redacted] Annual State Survey Results are Available at the Front Desk in the reception Area. On 9/15/22, an interview was conducted with the receptionist. When asked if Residents have access to the lobby since there is a door that requires a code to enter the lobby from the Resident care areas, Employee G confirmed that staff have to assist Residents and they do not have unrestricted access. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy regarding the posting of/accessibility of survey results was requested and not received. The facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings. No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41450 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to offer and/or provide Advance Directive planning for 2 residents, Resident #35 and Resident #111, out of a sample of 10 residents reviewed for Advance Directives. The findings included: The facility staff failed to offer and/or provide Resident #35 or their Responsible Party (RP) with Advance Directive planning. On 9/14/22, clinical record review was performed for Resident #35 and Resident #111 which revealed the following: 1. Resident #35 was readmitted to the facility on [DATE] following a hospital admission on 5/3/22. Physician orders and patient profile read, Full Code status which indicated that Cardiopulmonary Resuscitation would be initiated in the event of cardiac and/or respiratory arrest. The Quarterly Minimum Data Set (MDS), Assessment Reference Date (ARD) on 7/13/22 indicated that Resident #35 had a Brief Interview for Mental Status (BIMS) of 13, cognitively intact. 2. The facility staff failed to offer and/or provide Resident #111 and/or their Responsible Party (RP) with Advance Directive planning. Resident #111 was readmitted to the facility on [DATE] following a hospital admission on 8/18/22. Physician orders and patient profile read, Full Code status which indicated that Cardiopulmonary Resuscitation would be initiated in the event of cardiac and/or respiratory arrest. The MDS, Assessment Reference Date on 9/5/22 indicated that Resident #111 had a BIMS of 04, severe cognitive impairment. There was no documentation in the clinical record, for either Resident, that the facility staff offered or provided Advance Directive planning with Resident #35 and with Resident #111's Responsible Party (RP). On 9/15/22, an interview was conducted with the Director of Social Services (DSS) who confirmed the findings and stated that she was responsible for Advance Directive planning with residents and their families. She stated that for Residents #35 and #111, since they had no prior Advance Directives, they, or their RP, would have been given an Advance Directive booklet and offered assistance with planning. The DSS stated the Advance Directive conversations and provision of the booklet would have been documented in the Progress Notes, however she acknowledged the lack of documentation for Resident #35 and #111, stating, It must have been an oversight. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Advance Care Planning, effective date 9/18/20, read, .[name redacted] affirms the resident's right to make decisions regarding his/her medical care, including the decision to appoint a surrogate decision maker, make end of life wishes known, discontinue treatment, to the extent permitted by law while acknowledging the psychosocial and spiritual concerns of the resident and the family regarding the dying and the expression of grief by the resident and family. The same policy, subheading Procedure, item 7, read, The social services department is responsible for follow-up with the patient or representative for education and communication regarding Advance Care Planning. Item 8-b-2 read, Document in the electronic medical record using the specific record Advance Care Planning note whether or not a resident has executed an Advance Directive .A progress note regarding the conversation must also be documented. The Facility Administrator was informed of the findings on 9/15/22. No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, facility documentation review and clinical record review, the facility staff failed to complete a SNF (skilled nursing facility) NOMNC (notice of Medicare non-coverage) and ABN (advance beneficiary notice) timely and accurately for 2 Residents (Resident #417 and #35) in a survey sample of 3 Residents reviewed for Beneficiary Notifications. The findings included: 1. For Resident # 417, the facility staff failed to issue a NOMNC timely, therefore the Resident was not afforded the opportunity to file an appeal if she so desired. Resident #417, was admitted to the facility on [DATE], for skilled care. Resident #417 was issued a NOMNC on 3/31/21, which notified her that her skilled stay would end on 4/1/22. This notice did not afford the Resident adequate time to file an appeal if she chose to. Per the NOMNC, it read, Your request for an immediate appeal should be made as soon as possible, but no later than noon the day before the effective date indicated above. The appeal would have had to be filed by noon on 3/31/21, if she chose to appeal the decision. On 09/15/22 at 10:27 AM, an interview was conducted with the social worker (SW). The SW stated that with regards to timing of the notice, A NOMNC has to be issued with 48-72 hours' notice. She confirmed the purpose of the NOMNC is To help them understand their insurance will no longer be billed. When shown the NOMNC issued to Resident #417, the SW confirmed that the Resident was not issued the notice timely and did not have adequate opportunity to file an appeal. 2. For Resident #35, the facility staff failed to issue an accurate and timely ABN and NOMNC. Resident #35 was hospitalized and readmitted to the facility on [DATE], under Medicare Part A benefit/skilled care for therapy services. On 7/11/22, the facility staff contacted Resident #35's spouse and discussed that skilled care would end on 7/13/22. As per the NOMNC, Beginning on 7/14/22, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. According to the census tab of the electronic health record, Resident #35 began paying privately for his stay on 7/13/22, not 7/14/22. Therefore, his last day of Medicare Part A services was 7/12/22, and the NOMNC and ABN were not issued 2 days prior to services ending, nor were they accurate with regard to the date services would end. Therefore, he was not afforded the time required to make a decision if he wanted to appeal the decision. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility Non-coverage and Advance Beneficiary Notices Policy, was conducted. It read, .3) NOMNC a) Regulations state that we must notify residents, currently covered under Medicare that their coverage is ending. b) This is accomplished through the use of the NOMNC. i) This notice will be provided at least 2 days in advance of the last covered day to allow for adequate time to appeal, if the beneficiary so chooses . This above referenced policy also read, .6) SNF ABN- End of Covered Stay. a) If a resident is currently covered under Medicare and coverage is ending and the resident will remain in the SNF, the SNF ABN must be provided to the resident notifying them that someone else will need to pay for the SNF stay after Medicare ends. b) This could be private, Medicaid other insurance. c) This would be in addition to the NOMNC you already provided . According to Medicare, While you're getting SNF [skilled nursing facility] ., you should get a notice called Notice of Medicare Non-Coverage at least 2 days before covered services end. Accessed online at: https://www.medicare. gov/claims-appeals/your-right-to-a-fast-appeal/getting-a-fast-appeal-from-non-hospital-settings CMS identifies when the ABN is required to be issued in their document titled Form - Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) read, Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: Not medically reasonable and necessary; or Considered custodial. The Administrator was informed on 5/21/22, of the above findings. No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 41449 Based on observation, Resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to maintain a Resident's personal privacy and failed to protect personal health information for 3 Residents (Resident #35, 268, and 78) in a survey sample of 60 Residents. The findings included: 1. For Resident #35, the facility staff failed to provide a privacy curtain to ensure the Resident's personal privacy and dignity were protected during ADL (activities of daily living) care. On 9/14/22 at 9:30 AM, Resident #35 was visited in his room. The Resident requested of the surveyor, Can you see about getting me a privacy curtain. Surveyor B observed that there was no privacy curtain around Resident #35's bed. When asked where he changes clothes or takes a bath he said, Well, now I have to go into the bathroom to do it. On 9/14/22 at approximately 9:45 AM, an interview was conducted with CNA D. CNA D was asked what the purpose of a privacy curtain is, CNA D said, To protect their privacy. When asked if Resident #35's requires assistance with ADL's, CNA D said, Yes, because of his leg we have to help him. When he puts his pants on he sits on the bed and then we put the pants on him. Surveyor B told CNA D that Resident #35 reporting washing up/bathing in the bathroom, CNA D said, Sometimes we do it in the room and have him sit on the bed. CNA D confirmed Resident #35 had been without a curtain about two weeks because they said it was soiled. CNA D said, We just have to close the door and hope no one opens it while we are providing care. Review of Resident #35's clinical record confirmed that he requires assistance with ADL's, the care plan read, [Resident #35's name redacted], ADL Self Care Performance deficit, requires assistance with ADL r/t [related to] left femur fracture, surgery, impaired mobility, cognition. The facility policy regarding Resident privacy was requested and what was received was with regards to HIPAA and confidentiality of records/information, not personal privacy. The facility policy titled, Resident Rights was reviewed. This policy read, .d. To have their privacy respected when treatment, medication, or care is being administered including, i. door closed or privacy curtain drawn ii. Not have treatment, medication or care performed in common areas such as hallways, dining rooms or other including but not limited to 1. Personal care includes but not limited to a. Bathing, dressing, grooming, b. Nail care/ clipping (unless as an activity), c. Oral hygiene . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/15/22, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the above concern. The Administrator stated, This started about 2 weeks ago, I told them to change them. No further information was provided prior to the end of survey. 40026 2. For Resident # 268 the facility staff failed to ensure the privacy of his medical records by posting a marketing flyer (in the elevator) using his photo, medical diagnosis, and rehab progress . On 9/12/22 at approximately 2:00 PM Surveyor D observed a marketing flyer in the elevator that read: [Company name and logo redacted] Celebrating Success . We are pleased to share another wonderful rehab success story from: [Address and phone number of facility redacted. [Resident #269 name redacted] came to [Facility name redacted] from [hospital name redacted]. [Resident #269 name redacted] experienced a fall at home due to a Urinary Tract Infection, luckily no injuries sustained from the fall. [Resident #269 name redacted] had difficulty with walking and performing steps so he could return home. [Resident #269 name redacted] required help with his bathing, dressing, and toileting. [Resident # 269 name redacted] family was very supportive and very involved with his care. While at [facility name redacted], [Resident # 269's name redacted] made significant gains with his therapy plan of care, he was able to increase his walking abilities to over 350 ft. and was able to successfully navigate steps with no increased pain or assistance. [Resident #269 name redacted] was able to bathe, dress, and complete his toileting with little to no assistance. Name: [redacted] Admitting Diagnosis: UTI with a fall LOS: [length of stay] 34 days Discharge Location: Home [There was a graph on the page that showed his Functional Outcome Measures from Admission to Discharge for Bathing, Bed mobility, Grooming, Toileting, Upper body Dressing, Lower Body Dressing, Gait, Stairs, Transfers.] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/22 during the end of day meeting Surveyor D requested that the Administrator show documentation that Resident #269 approved or gave consent to disclose his protected health information (diagnosis of UTI and fall) that was used in the marketing flyer posted in the elevator, Surveyor D requested again on 9/13/22 and was told that the Administrator was awaiting for regional manger to get back to him. On 9/15/22 at 1:02 PM an interview was conducted with the Administrator and Employee D (the Regional Nurse Consultant). On 9/16/22 when the Admission package was reviewed it was found that the resident signed giving to use his photo however nothing was mentioned about using his protected health information along with his photo. The Administrator and Employee D (Regional Nurse Consultant) were both asked about permission to use his diagnosis and both stated that all they have is what is in the Admission Contract. [Please note the photo used was the admission photo showing Resident #269 in a hospital gown. On 9/16/22 an excerpt of the facility's HIPAA policy read as follows: 1 - To respect the privacy and confidentiality of any information you may have access to through our computer system or network and that you will access or use only that information necessary to perform your job . 3 - To disclose confidential resident, business, financial or employee information ONLY to those authorized to receive it . 7 - Not to release or disclose the contents of an resident or facility record except to fulfill your work. On 9/16/22 a review of the facility's Routine Resident Care Policy read: h. Maintains confidentiality of resident information at all times including but not limited to: i. photographs . ii. social media . iii. unauthorized email, fax, texting or telephone communication . iv. unauthorized communication in inappropriate environments such as open hallways, within the immediate vicinity of other residents/family or outside of the facility. On 9/16/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 40452 3. For Resident #78, the facility staff failed to protect personal health information by utilizing Resident #78's roommate and staff members from ancillary departments to interpret conversations due to a language barrier. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/12/2022 at 12:45 P.M., Resident #78 was observed in bed awake. When I asked if they had any concerns about the care received at the facility, Resident #78 motioned to their neck and pointed to their roommate, Resident #38. Roommate (Resident #38) stated that [Resident #78] cannot speak but responds to yes/no questions. The Roommate (Resident #38) also stated that [Resident #78]'s primary language is not English. This surveyor observed there were no communication aids in the room and no information about a language line was observed. The roommate (Resident #38) was asked if staff used interpreter to communicate with Resident #78, and the roommate stated staff sometimes ask her to interpret because she can also speak Resident #78's primary language. When asked what she is asked to interpret, the roommate Resident #38 stated, I let them know what food she doesn't like or I let them know when she has an upset stomach. On 09/13/2022, Resident #78 clinical record was reviewed. According to the Face Sheet under the section Primary Language, it was documented, English. According to the Admission Evaluation dated 09/13/2017 under the section entitled, Communication, the choices were English or Other. The option Other was selected and Spanish was written in the text box. On 09/14/2022 at 10:15 A.M., the Assistant Director of Nursing, RN E, was interviewed. When asked how staff communicate with Resident #78, the Assistant Director of Nursing (ADON) indicated she didn't know and stated Let me get that information for you. The ADON then stated that she would go to an interpretation site on the Internet. At approximately 10:18 A.M., CNA O was asked how staff communicate with Resident #78 and CNA O stated that there are two housekeepers that speak the same language as Resident #78. The staff were identified and placed in staff identifier as Employee Q, a laundry aide and Employee R, a housekeeper. On 09/15/2022 at 9:20 A.M., Employee Q was interviewed. When asked if the staff ask her to interpret for Residents, Employee Q stated that sometimes she would interpret but I only speak a little bit of English. When asked how often she serves as interpreter, Employee Q indicated she didn't understand the question and wanted to get her supervisor to interpret the question. On 09/15/2022 at 9:30 A.M., Employee R was interviewed. When asked if staff ask her to interpret, Employee R stated that the nurses ask her to interpret. Employee R also stated that she is not fluent in English but understands a little bit. When asked which Residents she serves as interpreter, Employee R stated Resident #78's name and Resident #6 in the sample. Employee R stated that sometimes Resident #6 will say she has pain in her leg or hip. Employee R stated Resident #6 speaks no English. When asked about Resident #78, Employee R stated that when she is interpreting for Resident #78, sometimes she will need medication. Employee R stated that Resident #78 Doesn't talk, only answers yes/no questions. I will ask her questions and she will answer. Employee R stated that she interprets when the doctor is seeing her and sometimes the nurses will ask me to go in there and check on her. On 09/15/2022 at approximately 6:45 P.M., the Administrator and Director of Nursing were notified of findings. On 09/20/2022 at approximately 10:35 A.M., Employee T, a physician, was interviewed. When asked how she communicates with Resident #78, the physician stated she asks the roommate to interpret sometimes or usually a maintenance person will do it. The physician also stated that she can speak a little bit of Resident #78's language but it was more difficult to understand her. The physician stated that Resident #78 points things out .points to things. When asked how long she had been caring for Resident #78, the physician indicated she has been seeing Resident #78 for 2 years. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/21/2022 at approximately 3:45 P.M., a copy of the facility's communication policy was requested and the Corporate Clinical Registered Nurse, Employee D, stated that they do not have a communication policy. A copy of their policy on protecting personal health information was requested and the facility staff provided a copy of their policy with the category entitled, Privacy and Security - Human Resources. The subject was entitled, Administrative Safeguards - Sanctions. The policy did not address safeguarding Residents' personal health information as it relates to communication management for Residents in need of interpretive services. The facility staff provided a copy of their policy entitled, Routine Resident Care in Section (1)(h), an excerpt documented, Licensed Staff will include the following services based upon their scope of practice, but not limited to: (h) maintains confidentiality of resident information at all times .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, Resident interview, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to maintain a clean, comfortable and home like environment for one Resident (Resident #46) and on two of two nursing units. The findings included: 1. The facility staff failed to maintain Resident rooms and bathrooms in a clean, comfortable and homelike manner for multiple Residents residing on both of the nursing units. a. On 9/12/22, during initial tour Surveyor B observed that a Resident residing in a room on the first floor, Colonial hall that had splatters and lines of a tan colored substance running down the wall at the head of the bed that were dried. Throughout the entire survey, which concluded on 9/22/22, Surveyor B observed the splatters and lines without any improvements noted. b. On 9/14/22, Surveyor B observed the following in a Resident room on the first floor, Washington hall. A bathroom with a large section of wall paper missing that measures approximately 15 inches wide and four inches long. The wall paper in the bathroom was peeling extensively and rolled up several inches in several bathrooms observed. Toilet tissue was stored on the sink in one bathroom because there was no center rod on the toilet tissue holder. c. On 9/14/22, Surveyor B observed the following in Resident rooms/bathrooms on the second floor [NAME] hall. A room with the baseboard missing on the wall beside the bathroom door. A room with paint peeling off of the wall and chunks of sheet rock missing which leaves exposed the metal strip that runs down the corner of the wall. Additional observations were made throughout the survey, which concluded on 9/22/22. There were no noted repairs, cleaning or improvements to the above. On 9/14/22, an interview was conducted with Employee F, the maintenance director. Employee F stated that the facility uses an electronic system for work orders and preventative maintenance. He also said sometimes staff will call down to the maintenance shop to notify them of repairs that are needed. Maintenance work orders for the month of September that had been completed and what was outstanding were requested. Upon review of the maintenance work orders for September there were no work orders with regards to the above findings or any other Resident room conditions noted above. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review was conducted of the facility policy titled, Maintenance Work Request System. This policy read, 1. Corrective maintenance can be defined as those actions required to restore equipment, buildings and grounds to normal condition and operation .2. The maintenance work request system will be divided by the environmental services department into three major categories which are defined as follows: A. Urgent .B. Routine .C. Deferred . 3. Ultimate priority assigned to the Work Request will normally be determined by the Department Director upon review of the written request .5. The Department Director will assign Work Requests to personnel and daily review completed work orders for completeness and correctness of repairs and/or the need for purchases or outside assistance. On 9/21/22, during an end of day meeting, the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings. No further information was provided. Complaint related deficiency. 40452 2. For Resident #46, the facility staff failed to maintain a comfortable homelike environment as evidenced by scuff marks and stains on the floor, baseboards, and walls. Also, the baseboard next to Resident #46's bed was separating from the wall and the baseboard to the right of the bathroom door was gone, revealing a small hole in the wall and ripped drywall. For Resident #46, the facility staff failed to maintain a comfortable homelike environment as evidenced by scuff marks and stains on the floor, baseboards, and walls. Also, there were strips of scotch tape on wall across from Resident #46's bed with ripped paper attached. Also, the baseboard next to Resident #46's bed was separating from the wall and the baseboard to the right of the bathroom door was gone, revealing a small hole in the wall and ripped drywall. On 09/13/2022 at 9:20 A.M., Resident #46 was observed lying in his bed. When asked about concerns with the facility, Resident #46 said everything was alright. When asked how he felt about the extensive amount of scuff marks, stains, and tape on the floor and walls, Resident #46 then pointed to the baseboard on the right side of his bed. This surveyor observed that the entire strip of baseboard was not tightly secured to the wall. Furthermore, the baseboard from the right side of the bathroom to the end of the wall was gone revealing a small hole in the wall and ripped drywall. On 09/13/2022 at approximately 5:30 P.M., the Administrator and Director of Nursing were notified of findings. On 09/20/2022 at approximately 2:45 P.M., Resident #46's room still had extensive scuff marks, stains, and tape on the floor and walls as well as loose/missing baseboards as observed on 09/13/2022. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/20/2022 at 3:20 P.M., the Maintenance Director, Employee F, and Employee U, maintenance staff, were interviewed. When asked about the process for work orders, the Maintenance Director stated that some requests are by word-of-mouth and some are put into the system. When asked about current work orders needing to be done, the Maintenance Director stated there were two work orders in the system. This surveyor and the Maintenance Director observed the work order screen and there was not a work order for Resident #46's room. When asked about any requests made for Resident #46's room, the Maintenance Director and Employee U both stated they were unaware of any work orders for Resident #46's room. At approximately 3:25 P.M., this surveyor, the Maintenance Director, and Employee U entered Resident #46's room for an observation of the loose/missing baseboard and hole in the wall. The Maintenance Director stated he was not aware of this and would fix it. The facility staff provided a copy of their policy entitled, Resident Rights. The policy did not address the Residents' rights to a clean, comfortable, homelike environment. 31199

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 40452 Based on observations, Resident interviews, staff interviews, clinical record reviews, facility documentation review, and in the course of a complaint investigation, the facility staff failed to promptly respond to grievances for 2 Residents (Resident #46, Resident #68) in a sample size of 60 Residents. The findings included: 1. For Resident #46, the facility staff failed to promptly respond after being notified of baseboards loose/missing in room as well as extensive scuff marks and stains on floor, baseboards, and walls. For Resident #46, the facility staff failed to maintain a comfortable homelike environment as evidenced by scuff marks and stains on the floor, baseboards, and walls. Also, there were strips of scotch tape on wall across from Resident #46's bed with ripped paper attached. Also, the baseboard next to Resident #46's bed was separating from the wall and the baseboard to the right of the bathroom door was gone, revealing a small hole in the wall and ripped drywall. On 09/13/2022 at 9:20 A.M., Resident #46 was observed lying in his bed. When asked about concerns with the facility, Resident #46 said everything was alright. When asked how he felt about the extensive amount of scuff marks, stains, and tape on the floor and walls, Resident #46 then pointed to the baseboard on the right side of his bed. This surveyor observed that the entire strip of baseboard was not tightly secured to the wall. Furthermore, the baseboard from the right side of the bathroom to the end of the wall was gone revealing a small hole in the wall and ripped drywall. On 09/13/2022, Resident #46's clinical record was reviewed. Resident #46's quarterly Minimum Data Set with an Assessment Reference Date of 07/22/2022 coded the Brief Interview for Mental Status as 6 out of 15 indicative of severe cognitive impairment. On 09/13/2022 at approximately 5:30 P.M., the Administrator and Director of Nursing were notified of findings. On 09/20/2022 at approximately 2:45 P.M., Resident #46's room still had extensive scuff marks, stains, and tape on the floor and walls as well as loose/missing baseboards as observed on 09/13/2022. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/20/2022 at 3:20 P.M., the Maintenance Director, Employee F, and Employee U, maintenance staff, were interviewed. When asked about the process for work orders, the Maintenance Director stated that some requests are by word-of-mouth and some are put into the system. When asked about current work orders needing to be done, the Maintenance Director stated there were two work orders in the system. This surveyor and the Maintenance Director observed the work order screen and there was not a work order for Resident #46's room. When asked about any requests made for Resident #46's room, the Maintenance Director and Employee U both stated they were unaware of any work orders for Resident #46's room. At approximately 3:25 P.M., this surveyor, the Maintenance Director, and Employee U entered Resident #46's room for an observation of the loose/missing baseboard and hole in the wall. The Maintenance Director stated he was not aware of this and would fix it. The facility staff provided a copy of their policy entitled, Resident Grievance. Under the header Policy an excerpt documented, The facility recognizes that residents have a right to voice grievances to the facility, or other agencies or entities that hear grievances, without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment that has been furnished, the behavior of staff and other residents and any other concern regarding the resident's stay. 2. For Resident #68, the Administrator failed to respond to Resident #68's multiple messages and urgent requests to speak with him over a 4-month period (May-September 2022). On 09/12/2022 at approximately 12:35 P.M., Resident #68 was interviewed. When asked if he had any concerns about the care he receives at the facility, Resident #68 stated that he has asked to speak with the Administrator multiple times but the Administrator never shows up. When asked what he would like to talk with the Administrator about, Resident #68 stated that he is supposed to be receiving physical therapy but not getting it. Resident #68 also stated it takes staff up to 45 minutes to answer the call light sometimes. Resident #68 stated that he has epilepsy and may be alone having a seizure by the time staff respond to the call light. Resident #68 also stated that he has had a stroke before and I could've had a stroke but I would be dead by the time I get a medical response. When asked if he filed a grievance, Resident #68 nodded his head yes. Resident #68 stated he calls the front desk and leaves messages for the Administrator. Resident #68 stated that the secretary at the front desk has a call log to show how many times he has called. When asked if he was informed of the facility's process for filing a grievance, Resident #68 stated, No. On 09/13/2022 at 11:00 A.M., the receptionist, Employee G, was interviewed. When asked about Resident #68 calling to ask to speak with the Administrator, the receptionist stated that [Resident #68] calls all the time. The receptionist verified she has a call log and provided a copy of the call logs for June, July and August 2022. There were 12 messages from Resident #68 for the Administrator. The dates, times, and messages were as follows: 06/14/2022 at 1:50 P.M. Would like for you to call him when you get the chance. 06/28/2022 (not timed) Please call-it is urgent. 07/12/2022 at 4:32 P.M. Calling in regards to a missed meeting you guy had set up. 07/13/2022 (not timed) Please see him re: [regarding] the conditions of his living condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/21/2022 (not timed) Would like to speak with you. 07/28/2022 at 11:26 A.M. Please call [Resident #68]. He said he has been trying to speak to you for about 6 weeks. 08/09/2022 at 4:26 P.M. His 14th time trying to reach you - if you don't contact him, he will call corporate office. 08/09/2022 at 4:36 P.M. This is his 14th time trying to contact you. He will call corporate office. 08/12/2022 at 6:00 P.M. Would like to speak with you about why the 2 meetings he had scheduled with you didn't occur. 08/15/2022 at 12:46 P.M. Called and would like to speak with you. 08/16/2022 (not timed) Would like to speak with you regarding his treatment. On 09/21/2022 at approximately 4:15 P.M., the Administrator was notified of findings. When asked how Residents are made aware of grievance policy, the Administrator stated there are grievance forms at every nursing station and staff let them know they can complain to any of us. When asked if the multiple messages left by Resident #68 were addressed, the Administrator stated that he goes and meets with [Resident #68] and many times, makes appointments. When asked for evidence that the Administrator addressed Resident #68's concerns, the Administrator confirmed there is no documentation to support that Resident #68's messages were answered and addressed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40452 Based on observation, Resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to protect 5 Residents from abuse (Resident #63, #322, Resident #70, #52, #21) and failed to protect 2 residents from neglect (Resident #35, Resident #217) in a sample size of 60 Residents. Immediate Jeopardy was called on 09/16/2022 at 4:34 P.M. On 9/21/22 at 12:15 P.M., the survey team verified the implementation of the removal Plan submitted by the facility and the scope and severity was lowered to E at that time. The findings included: Resident #68's quarterly Minimum Data Set with an Assessment Reference Date of 08/02/2022, Resident #68's medical diagnoses included but were not limited to Bipolar disorder. Resident #68's Brief Interview for Mental Status was coded as 10 out of possible 15 indicative of moderate cognitive impairment. Functional status for walking in room and corridor were coded as requiring supervision from staff without a mobility device. The facility staff provided a copy of two Resident-to-Resident Facility-Reported Incidents (FRI) involving Resident #68 and his roommates: 1) For Resident #63, the facility staff failed to protect Resident #63 from Resident #68, a Resident with known aggressive behaviors, resulting in Resident #68 verbally assaulting Resident #63 with a threat of physical harm on 09/15/2022 According to Resident #63's quarterly Minimum Data Set with an Assessment Reference Date of 08/03/2022, Resident #63's medical diagnoses included but were not limited to depression and schizoaffective disorder. Resident #63's Brief Interview for Mental Status was coded as 11 out of possible 15 indicative of moderate cognitive impairment. Functional status for bed mobility, dressing, and personal hygiene were coded as requiring extensive assistance from staff. On 09/15/2022 at 5:30 P.M., the Ombudsman entered the conference room to speak with the survey team. In the course of the conversation, the ombudsman stated that about 20 minutes ago she heard (Resident #68) tell his roommate (Resident #63) he was going to come over there (in a threatening tone). The ombudsman stated that she told nursing staff. On 09/16/2022 at approximately 8:40 A.M., Resident #63's progress notes were reviewed. An excerpt of a nurse's note dated 09/15/2022 at 8:45 P.M. documented, At around 6:15 pm assigned CNA [Certified Nursing Assistant] for [Resident #63] in room [number] told charge nurse on unit, ombudsman reported to her both residents in room [number] were having verbal altercation. Writer immediately went into residents [sic] room, asked what was the problem. [Resident #63] stated his roommate stepped into his personal space and always have his door closed, he feels so lonely in his corner [B bed] and no fresh air coming into his room and his roommate does not want him to turn his radio on, his roommate always tell him to shut up when he wants to speak. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/16/2022 at approximately 8:50 A.M., Resident #68's progress notes were reviewed. An excerpt of a provider note dated 09/15/2022 at 8:48 P.M. documented, Resident had altercation with roommate, roommate transferred [sic] to another floor and room. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: separation of residents, psych evaluation ordered in [electronic health record]. An excerpt of a nurse's note dated 09/15/2022 at 11:08 P.M. documented, At around 6:15 pm assigned CNA for [Resident #68] told charge nurse on unit, ombudsman reported to her both residents in room [number] were having altercation. Writer immediately went into residents room, asked what was the problem. [Resident #68] stated earlier during dinnertime, he was talking to the CNA, [Resident #63] had accused him of breaking into his home, and would call the cops on him, and [Resident #63] has his radio on loud all day and night, whenever he asks him to lower his radio, they get into an argument. On 09/16/2022, the facility staff provided a copy of the FRI of the incident. A handwritten statement dated 09/15/2022 from CNA P documented, To my knowledge, I was delivering dinner trays to [Resident #68]'s room he began complaining about his tray and asked for the top to keep his food hot. Bed B [Resident #63] assumed he was talking to him, and began telling me that he wanted to call the police because Bed A [Resident #68] had broken into his home. Bed A [Resident #68] told Bed B [Resident #63] 'Hey she was not talking to you!' Bed B [Resident #63] said, 'Shut up', Bed A [Resident #68] said 'You shut the hell up you S.O. B.' I intervened, changing the subject. Both people calmed down. 2) For Resident #322, the facility staff failed to protect Resident #322 from Resident #68, a Resident with known aggressive behaviors, resulting in Resident #68 hitting Resident #322. FRI #1) Incident date 09/13/2020 with Resident #322. According to the incident description, there was a loud exchange of words heard by staff between Resident #68 and Resident #322 about whether or not to close the room door resulting in Resident #68 hitting Resident #322 on the back of his head. According to the 5-day follow-up report dated 09/17/2020, an excerpt documented, Education was provided to each resident about respecting other individuals' space and no physical contact without consent from the other individual. 3) For Resident #70, the facility staff failed to protect Resident #70 from Resident #68, a Resident with known aggressive behaviors, resulting in Resident #68 physically assaulting Resident #70 on 06/01/22. According to Resident #70's quarterly Minimum Data Set with an Assessment Reference Date of 08/05/2022, Resident #70's medical diagnoses included but were not limited to cerebral infarction, hemiplegia, and hemiparesis. Resident #70's Brief Interview for Mental Status was coded as 14 out of possible 15 indicative of intact cognition. Functional status for bed mobility and transfers were coded as requiring extensive assistance from staff. Functional limitations in range of motion were coded as 1 meaning impairment on one side for upper and lower extremities. Urinary and bowel continence were coded as 3 meaning always incontinent. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	FRI #2) Incident date 06/01/2022 with Resident #70. An excerpt of an Activity staff member handwritten statement documented, I went into [room number] to see [Resident #68]. I asked [Resident #70] who was in (Bed A) where is [Resident #68] and [Resident #70] stated that he was in the bathroom-he always in the bathroom. I asked [Resident #68] how long will he be in the bathroom so [Resident #68] came flying out of the bathroom and rushed toward [Resident #70] saying I'm sick and tired of him. I tried to hold [Resident #68] back and he pushed me out of the way and put his hands in [Resident #70]'s face and then pushed his face and [Resident #70]'s head went to the edge of the bed. An excerpt of the Follow-Up Report written by the Director of Nursing dated 06/03/2022 under the section entitled Conclusion documented the following excerpt pertaining to Resident #68: behavior problems of being verbally abusive to staff and other residents, and he is receiving treatment to manage his health conditions. Resident has also been seen by the psychiatric NP [nurse practitioner] related to this behavior problems [sic]. Staffs [sic] will continue to monitor him closely, assist with care as needed, assess for pain, skin and will report any abnormal findings or behavior symptoms to the MD/NP. On 09/16/2022, Resident #70's clinical record was reviewed. An excerpt of a nurse's note dated 06/01/2022 at 10:00 A.M. documented, At around 10:00 am staff member called this writer's attention, staff member stated that she witnessed [Resident #70]'s roommate pushed [Resident #70]'s face while he was lying in a bed. When this writer arrived at the room I observed [Resident #70] lying in bed. Immediately separated them. Head-to-toe assessment done on [Resident #70]. No skin issues were observed, and no bruise or skin discoloration was noted. [Resident #70] denies any pain or discomfort. Resident #68's clinical record was reviewed. A nurse's note dated 06/01/2022 at 4:53 P.M. documented, Note Text: Writer was called to resident [#68] room by activity staff that the resident pushed his roommate's [Resident #70] face. Immediately writer went to the resident's room and the activity staff said she came to the resident's room to do an assessment on the resident's roommate at about 10:20 am. While the activity staff was conducting her UDA assessment on the resident's roommate who was lying on his bed, the activity staff asked the roommate about the resident, meanwhile, the resident was in the bathroom and he heard the activity staff asking about him. The resident's roommate then said to the activity staff Resident was in the bathroom and he's been there for too long. The resident while in the bathroom came out of the bathroom and started saying he is tired of his roommate and rushed toward roommate and pushed his face. The activity staff tried to stop him and resident rushed to the roommate who was lying on the bed and pushed his face. The resident was accompanied out of the room by the nurse. Head to toe assessment done on the resident's roommate and upon assessment, no bruises, no swelling, no skin tear, no discoloration, no injury, no s/s [signs/symptoms] of trauma noted. The resident also was assessed and no s/s of trauma noted and denies pain. The resident was immediately moved to another room and was separated from the roommate. The resident was asked why he pushed the roommate's face and the resident said 'I am tired of my roommate talking about me.' Resident was calmed at this time and was educated not to put his hand on any resident. Resident [#68] with history and diagnoses of Behavioral with major depressive disorder, bipolar disorder, yelling, complaining and using abusive language. MD [medical doctor] and RP [responsible party] made aware, new ordered [sic] for psych consult and evaluation. 911 was called spoke with officer [name], case number [number] Resident was separated and room changed to another wing on same unit. Resident is been monitored closely for any further behavior. The social worker was called and also spoke with the resident regarding his behavior. The resident remain calmed [sic] and in his new [sic] adjusting well with no complaints at this time. Resident was moved with all his belongings and the resident checked and made sure all his belongings were moved. We will continue with the plan of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/20/2022 at 10:40 A.M., Resident #70 was interviewed. When asked about the experience of being a roommate with [Resident #68], Resident #70 stated, It was terrible. Resident #70 also stated, He would yell at me plenty of times. When asked about the incident on 06/01/2022, Resident #70 explained that a staff member entered the room and asked where [Resident #68] was and he told the staff member that [Resident #68] was in the bathroom. Resident #70 added, He was usually in the bathroom. Resident #70 then stated that after he said that, Resident #68 came over and hit me. On 09/15/2022 at 6:15 P.M., the Administrator, the Director of Nursing, and the Social Worker were interviewed. When asked about Resident #68's altercations with roommates, the Social Worker stated Resident #68 was moved into a room with Resident #70. The social worker stated that there was an altercation between Resident #68 and Resident #70 so Resident #68 was then moved into a room with Resident #63. When asked how the facility staff determines which Resident would be a compatible roommate with Resident #68, the social worker stated that Resident #68 prefers to have a bathroom to himself so they opted to pair him with a roommate that is non-ambulatory and does not use the bathroom. 4) For Resident #52, the facility staff failed to identify and implement measures to protect Resident #52 from staff verbal abuse. On 09/14/2022, Resident #52's clinical record was reviewed. Resident #52's Minimum Data Set with an Assessment Reference Date of 07/27/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 10 out of possible 15 indicative of moderate cognitive impairment for that 7-day look-back period. On 09/15/2022, the facility staff provided a document dated 09/13/22 entitled, Concern Form for Resident #52. Under the header Description of Concern it was documented, Resident verbalize [sic] staff yells at her. Under the header Actions to resolve the concern documented, Social Services interviewed all residents w/a [with a] BIMS [Brief Interview for Mental Status] score of 12 and above with no concerns voiced of verbal, physical, or sexual abuse. The document was signed by the Social Worker on 09/14/2022 and the Administrator on 09/15/2022. On 09/15/2022 at 1:00 P.M., a copy of the Facility-Reported Incident (FRI) related to Resident #52's allegation of abuse on 09/13/2022 was requested from the administrator. The Administrator stated a grievance form was filed and an investigation was started. There was no evidence in the packet that the allegation of abuse reported on 09/12/2022 by Resident #52 was reported to the state agency or an investigation initiated. On 09/13/2022 at 11:00 A.M., a Resident Council meeting with 6 Residents was conducted. Resident #52 stated that the aides appear angry, not giving good service. Resident #52 also stated staff was yelling at me. Resident #52 also indicated she didn't want to provide names. Resident #52 also stated she had experienced retaliation for reporting issues and did not want to elaborate further at the time of the meeting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/15/2022 at approximately 5:30 P.M., the ombudsman entered the conference room to speak with surveyors. When asked if Residents expressed fears of retaliation, the Ombudsman stated, Yes and went on to explain that at least three very cognitively intact Residents said that they didn't want to say anything because they will get yelled at or they [the staff] will be mean or not respond to the call light. When asked if this information was passed along to Social Services or Adult Protective Services, the ombudsman stated No, that's a gray area for me. On 09/15/2022 at 6:25 P.M., the Administrator was interviewed. When asked about the process for allegations of verbal abuse, the Administrator stated that staff would put a note in the system and it would be investigated and reported initially to the state agency within 2 hours and a follow-up report would be sent to the state agency in 5 days. When asked about a FRI regarding Resident #52's allegation of verbal abuse, the administrator stated a FRI was not done. The facility staff provided a copy of their policy entitled, Abuse, Neglect, and Exploitation. In Section VII, part viii, entitled, Reporting and Response an excerpt documented, Residents who are abusive to other residents must be monitored and must have a care plan that addresses the abusive behavior. Those who are victims of abuse must be protected from further injury or mental anguish. 40026 4. For Resident # 21 the facility staff failed to protect the Resident from physical abuse by staff. On 5/1/22 the facility submitted a FRI (Facility Reported Incident) to the OLC (Office of Licensure and Certification) regarding an allegation of abuse of Resident #21 by LPN F. The FRI read: Describe incident, including location, and action taken: CNA [name redacted] reported seeing a male nurse, [name redacted] hit Resident from behind the privacy curtain in room [ROOM NUMBER]. Resident was assessed w/o [without] injury. Employee action initiated or taken - [Employee name redacted] placed on suspension 5/1/22 pending investigation. The investigation contained a statement from the CNA that witnessed the incident. The CNA stated in her witness statement, that she went downstairs upset and was told that they would notify the DON however the CNA stated she did not trust the DON due to hearing her say Stuff like that does not happen on my floor. The CNA went outside and called the police to report the abuse and that the police came and took her statement. A review of the time card punches revealed that the LPN F was never placed on suspension. He continued working and had even been assigned to her unit several times after the incident. LPN F was still an active employee until 9/16/22 when he was terminated during the survey. A review of the employee file included the license verification completed on hire. LPN F's license verification read: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Additional Public Information - YES [Please note when YES comes up on a license verification it is indicative of the licensee being brought before the Board of Nursing, and the facility needed to click the Yes to find out what the further information was] The facility had no evidence that they had not checked to see what that further information was until after this incident took place. During the course of their investigation of the incident they found that the nurse had been terminated from 2 previous facilities for negligence and verbal abuse of Residents. The nurse was terminated from employment on 9/16/22. On 9/16/22 the Administrator was made aware of the concerns and no further information was provided. On 09/16/2022 at 4:34 P.M., immediate jeopardy was called. On 09/16/2022 at 4:49 P.M., the Administrator was notified. On 09/21/2022 at 12:15 P.M., the removal plan was accepted by the survey team. The facility presented the following removal plan. 1. Resident #68 placed on 1:1 supervision to ensure other residents are protected from abuse. Resident #68 was moved to a room with no roommate. Attending physician and responsible party informed. Psychiatric evaluation will be completed. Resident #63 assessed by social worker for psychosocial effect from verbal abuse of resident #68. Head to toe assessment done and PTSD screen completed, no new findings. Social worker referral and psych consult will be done. Based on assessment findings appropriate therapeutic measures will be implemented to protect resident. 2. Resident #52 self-report of allegation of abuse completed 9/16/22 by administrator. Resident #52 was assessed by social worker for psychological effect of abuse. Head to toe assessment and PTSD screen, no new findings noted. Resident interviewed by social worker. To identify staff who committed the verbal abuse all staff will be investigated to ensure a thorough investigation is completed. Appropriate action including termination will be taken for any staff identified as committing the alleged abuse. 3. Regional Director of Operations educated facility leadership team on 9/16/22 on organization abuse, neglect and exploitation policy. Facility Staff Development Coordinator is re-in servicing all staff on abuse, neglect and exploitation policy. 4. Facility leadership team is currently interviewing all Interviewable residents for abuse. Head to toe skin assessments will be completed for non-Interviewable residents. Residents' responsible parties will be contacted to gather information on abuse that may have occurred in the past 90 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. LPN F employment terminated on 9/16/22. LPN F last worked in facility 6/15/22. The survey team verified the following items listed in the removal plan: A FRI dated 09/16/2022 was completed for Resident #52. Resident #52 was assessed by the social worker. Resident #68 was placed 1:1; staff stationed outside his room, and no roommate. Psychiatric evaluation for Resident #68 was completed. Resident #63 was assessed by the social worker, head-to-toe assessment completed, PTSD screen completed, and psychiatric consult completed. All staff were educated on abuse, neglect, and exploitation policy. All interviewable Residents were interviewed to screen for abuse. Skin assessments were performed on all non-interviewable Residents Responsible Parties were interviewed to gather information on abuse. A head-to-toe assessment and a PTSD [post-traumatic stress disorder] were completed for Resident #52. All staff were educated on abuse, neglect, and exploitation policy. All interviewable Residents were interviewed to screen for abuse. Skin assessments were performed on all non-interviewable Residents. Responsible Parties were interviewed to gather information on abuse. On 9/21/22 at 12:15 P.M., the survey team verified the implementation of the removal Plan submitted by the facility and the scope and severity was lowered to E at that time. 41449 5. For Resident #35 the facility staff neglected to provide a blanket after the surveyor and the Resident made the request to facility staff. On 9/12/22 at 3:26 PM, an interview was conducted with Resident #35. During the interview, when asked about the temperature in the facility, Resident #35 stated he would like another blanket because he gets cold at night. While in the room with Resident #35, Surveyor B observed CNA F at the doorway, in the hall. CNA F had a linen cart, Surveyor B observed blankets on the cart and approached the doorway and said, He [Resident #35] would like another blanket, he says he gets cold at night. CNA F responded, We are making our rounds, I may need them for other people but it will be taken care of. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	CNA F then entered the room and handed Resident #35 a hospital gown and said, This is for later tonight. Resident #35 said, I like the gown because it keeps my clothes fresher, but it gets cold at night, I don't know if I can wear it all night. May I have a blanket? CNA F said, Let me make my rounds since you already have one. Resident #35 responded, It's a thin blanket. CNA F said again, Let me see if anyone else needs one first, and CNA F exited the room. Resident #35 then told Surveyor B, They say I bother them and they are busy working on reports, they just tell me to go wait in my room, they don't listen to you. On 9/12/22 at approximately 4:00 PM and again at 4:30 PM, Surveyor B went to laundry and knocked on the door without any response. On 9/12/22 at 5:12 PM, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the above findings. The Administrator confirmed that the facility linen supply is good. When asked, if a Resident asks for a blanket what response would you expect. The Administrator said, They have to give it to them immediately. The DON said, You can't do that. The Administrator said he would define this as neglect. Following the end of day meeting, Surveyor B asked the Administrator to provide access to laundry, so the supply of linen could be observed. The Administrator was unable to find any staff to unlock the laundry door and gain access prior to the survey team leaving for the day at 5:45 PM. On 9/13/22, the facility Administrator provided the survey team with a Facility Reported Incident (FRI) that had been submitted that read, Surveyor witnessed Resident being verbally abused by staff employee regarding resident asking for blanket .Resident was immediately provided multiple blankets when brought to the ED's [executive director] attention. The Administrator also indicated that the employee [CNA F] has been suspended pending the investigation. On 9/13/22 at 8:15 PM, Surveyor B observed the 2 linen carts on the second floor, where Resident #35 resided and observed blankets available. The facility abuse policy was reviewed. This policy read, Neglect: means a failure to provide timely and consistent services, treatment or care to a resident or resident's which are necessary to obtain or maintain the resident's health, safety or comfort . No further information was provided. 34894 6. For Resident # 217, the facility staff failed to provide services to protect from neglect on 5/28/2020. Resident # 217 was admitted to the facility on [DATE] for skilled services in nursing and therapy with the diagnoses of, but not limited to, Asthma, Congestive Heart Failure (CHF), Chronic Kidney Disease Stage 3, Hypertension, Atrial Fibrillation, Obstructive Sleep Apnea (OSA), Infection due to Multi-resistant organism and Morbid Obesity with BMI (Body Mass Index) 60-69. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Resident # 217's closed clinical record revealed the most recent MDS (Minimum Data Set) was a Quarterly Assessment with an ARD (Assessment Reference Date) of 9/16/2021. The MDS coded Resident #217 as requiring extensive to total assistance of one to two staff persons with activities of daily living and frequently incontinent of bowel and bladder. Review of the clinical record was conducted on 9/12/2022-9/22/2022. Review of the Progress Notes revealed documentation of a nurses note dated 5/28/2020 at 8:19 a.m. which stated: Resident The CNA (Certified Nursing Assistant) and I transferred (gender redacted) to the wheelchair. At around 10:30 p.m., I asked the CNA to help put (gender redacted) back to bed because it would be difficult if nobody is around to put (gender redacted) to bed. Resident refused to go to bed. (gender redacted) later on asked to be put to bed and I said (Resident # 217's name redacted) not by myself. I will need someone to help me. There was nobody at the moment and (gender redacted) was in the wheelchair for a while until when (Name of CNA redacted) came to help with (name of another resident redacted), then we put (gender redacted) to bed. On 9/20/2022, an interview was conducted with the Regional Nurse Consultant who read the Progress note and stated That's abuse. The Regional Nurse Consultant stated the nurse should have assisted the resident back to bed upon request. Resident # 217 should not have had to wait in the wheelchair for an extended time as documented by the Licensed Practical Nurse (LPN K). There was no documentation of the amount of time the resident waited. There was no documentation of the LPN trying to get another staff member to assist with the transfer from wheelchair to bed. Resident # 217 had a history of Asthma, and Congestive Heart Failure. The MDS coded extensive assistance of two staff persons for transfers and bed mobility. On 9/21/2022 during the end of day debriefing, the facility administrator, Director or Nursing, Regional Nurse Consultant and Regional Consultant were informed of the findings. The Administrative staff stated they were unaware of the incident that was documented on 5/28/2020 in the progress notes by LPN K (Licensed Practical Nurse K) . On 9/21/2022 at 10:45 a.m., an interview was conducted with the Human Resources Director who stated LPN was no longer employed at the facility. She also stated the CNA was no longer employed at the facility. On 9/21/2022 at 11 a.m., the Human Resources Director stated LPN resigned on 10/19/2021. When asked again if there were any disciplinary actions in the record, The Human Resources Director stated she would check the file for any disciplinary actions. Federal regulations describes neglect as: the failure of the facility , it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the facility's policy on Abuse, Neglect and Exploitation Effective 5/1/2017, Reviewed 11/22/2019, Revised 10/27/2021 revealed the following excerpts about Neglect: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Neglect means a failure to provide timely and consistent services , treatment or care to a resident or resident's which are necessary to obtain or maintain the resident's health safety or comfort or a a failure to provide timely and consistent goods and services to avoid physical harm, mental anguish, or mental illness During the end of day debriefing, the facility's administrative staff was informed of the findings that the nurse, LPN (Licensed Practical Nurse) K, failed to assist Resident # 217 back to bed. Resident # 217 had gotten up earlier in the shift due to experiencing Shortness of Breath and difficulty breathing. LPN K was no longer employed at the facility at the time of the survey when the nurses note was discovered. The CNA mentioned in the note also was no longer employed at the facility. No further information was provided. COMPLAINT DEFICIENCY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 41449 Based on Resident interview, facility staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure Residents' were free from misappropriation and exploitation for three Residents (Resident #35, 368 and 70) in a survey sample of 60 Residents. The findings included: 1. For Residents #35 and #368, who were married, were victims of financial misappropriation and were exploited of money in excess of $50,000 by a facility employee, which resulted in fear of economic hardship and mistrust, which constituted harm. On 9/12/22 at 3:07 PM, an interview was conducted with Resident #35. Resident #35 said, I had trouble when I first came here, thieves got hold of the books and it was a minor thing to them. I woke up one morning and the checking account was down to zero. It was an inside job, no one cared about how the books were managed. I would rather go home and do the best we can versus stay here and go broke. When asked if he worries about the ability to pay for continued care, Resident #35 said, Yes. On 9/15/22 at 4 PM, a follow-up interview was conducted with Resident #35. He stated, $70,000 was taken. We used a check to pay the facility because it wasn't covered by Medicare, we wrote a check for the amount due and they never paid the business office. Another check was written and they went to a young teller and got the money and we were down to zero. When asked how did this make him feel, Resident #35 said, I will be blunt. My wife is starting to get tarnished in her trust in people. I want to get out of here because of how they run their accounting and they see nothing wrong with it. It all started here, $4,000 my wife paid was charged to us again, and then another $5,000, looks like the hands of thieves are in it again. On 9/21/22 at 9:54 AM, an interview was conducted with Resident #368. When asked about the incident, Resident #368 said, I'm not sure who took it. A lady there released me and she wanted over $5,000 from me and never took it to the business office. They stole all our money. I'm having so much trouble with that business office. Resident #368 confirmed she feels taken advantage of. The interview was terminated because Resident #368 became very upset and tearful and said, I don't like what is going on. A lot of nights I lay awake and can't sleep, it's awful I sit here and cry a lot. Now I have to worry about money all the time. On 9/15/22, an interview was conducted with Adult Protective Services (APS). They were able to provide information regarding their investigation which revealed a preponderance of evidence to substantiate that Residents #35 and 368 were victims of financial exploitation by a facility employee in excess of $50,000. Their investigation was turned over to financial crimes department with the police. On 9/15/22, an interview was conducted with the investigator from the police department. He stated, Based on the evidence of the investigation thus far, we are able to determine it did take place and Residents #35 and 368 were victims of misappropriation and exploitation by an employee of the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Actual harm Residents Affected - Few	The facility provided the survey team with a Facility Reported Incident (FRI) that was completed on 5/2/22, regarding this allegation of misappropriation. On 9/13/22, 9/15/22, and again on 9/16/22, the facility Administrator was asked to provide all documentation regarding this FRI, investigation, etc. Review of the facility reported incident/investigation revealed an investigation follow-up letter dated 5/4/22. This letter/report indicated that Resident #35 and 368's bank fraud department is how the concerns of fraud were identified and the bank reported the concerns to Resident #368. The report further stated that the facility was cooperating with the police department's investigation. There was no indication that any conclusion was made in the facility level investigation, nor that any correction/restitution had been made to Residents #35 and #368 to alleviate their duress. In the investigation documents there was evidence of checks written by Resident #35 and #368, drawn on their joint bank account that were endorsed by a facility employee for personal use/gain. The employee was able to coerce Resident #368 to write checks to her and additionally the employee intercepted payments mailed to the facility, endorsed the checks and obtained the money her/himself. Additional documentation received from the facility included collection notes and activity regarding Resident #35. a. The notes dated 4/21/22, read, s/w [spoke with] [Resident #368 name redacted] and she stated that [facility name redacted] had cleaned them out . b. An excerpt from the notes dated 5/2/22 read, I received a call from the wife [name redacted] on Friday, April 29, 2022. She stated that her bank account was wipe out by [facility name redacted]. I asked her does she know if it was for [hospital name redacted]. She said no, it was the nursing home. She stated that it was about $50,000.00 that was stealing out of her account [sic] . The facility staff reported they have been unable to find the employee file of the perpetrator. Therefore, they had no evidence that they had taken appropriate measures prior to hiring the employee to ensure they were not a threat to the residents. The facility policy titled, Abuse, Neglect and Exploitation Policy was received and reviewed. This policy read, . Misappropriation of Property: means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a Resident's belongings or money without the resident's consent . On 9/21/22, during end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware the survey team had concerns regarding the Residents being exploited and misappropriation of money by a facility employee. No further information was received. 2. For Resident #70, the facility staff misappropriated money in the amount of $3,580.04. On 9/19/22, Resident #70 disclosed during an interview concerns about a check he received from a prior facility he lived at, not being deposited into his bank account/trust fund. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Actual harm Residents Affected - Few	On 9/19/22, Surveyor B asked for a transaction history of Resident #70's account and related documents. The requested items were received and reviewed. The findings were as follows: a. A copy of the check written to Resident #70 from another skilled nursing facility dated 7/15/21, in the amount of $3,580.04, was provided. b. The transaction history showed the above referenced check was deposited into Resident #70's trust account on 8/30/21. c. On 8/30/21, a withdrawal in the amount of $3,580.04 was made and applied towards care costs. Meaning, the funds were withdrawn and paid to the facility. d. Evidence of the Medicaid patient liability did not indicate Resident #70 owed these funds to the facility. On 9/20/22, an interview was conducted with Employee J, the Regional Director of Revenue Cycle who was present in the absence of the facility business office manager. Employee J was asked if she had any significant findings from the review of the documents Surveyor B had requested for Resident #70. Employee J said, yes, she had identified that they were deducting the wrong amount from Resident #70's account for the cost of care and was not certain why this had been done. When asked specifically about the check in the amount of $3,580.04, being withdrawn and paid to the facility. Employee J said, I am not sure why that was done, it wasn't owed to the facility. The facility policy titled, Abuse, Neglect and Exploitation Policy was received and reviewed. This policy read, . Misappropriation of Property: means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a Resident's belongings or money without the resident's consent . On 9/21/22, during an end of day meeting, the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings. No further information was provided. Complaint related deficiency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on Resident interview, staff interview, clinical record review, facility documentation review, and during the course of a complaint investigation, the facility staff failed to implement their abuse policy for 10 Residents (Resident #35, 117, 31, 84, 367, 369, 19, 52, 217, and 21) in a survey sample of 60 Residents. Additionally, the facility staff failed to implement their abuse policy by (1) not obtaining criminal background checks for 13 employees (Staff #5, #6, #7, #8, #10, #11, #12, #13, #14, #15, #16, #21, and #23) in a sample of 25 employee records reviewed, (2) not performing professional license verification for 13 licensed employees (Staff #3, #5, #7, #8, #10, #11, #13, #18, #19, #20, #21, and #23) in a sample of 19 licensed employee records reviewed and (3) not providing staff abuse/neglect training for 3 employees (Director of Nursing, CNA B, and CNA C) in a sample of 5 employee training records reviewed. The findings included: 1. For Resident #35, the facility staff failed to implement their abuse policy with regards to the timely reporting of an allegation of misappropriation of money and failure to conduct pre-hire screening of the employee who misappropriated money and exploited the resident. On 9/12/22 at 3:07 PM, an interview was conducted with Resident #35. Resident #35 said, I had trouble when I first came here, thieves got hold of the books and it was a minor thing to them. I woke up one morning and the checking account was down to zero. It was an inside job, no one cared about how the books were managed. On 9/15/22, an interview was conducted with Adult Protective Services (APS). They were able to provide information regarding their investigation which revealed a preponderance of evidence to substantiate that Residents #35 and 368 were victims of financial exploitation by a facility employee in excess of $50,000. On 9/15/22, during an interview with Adult Protective Services (APS), Surveyor B was notified that APS had called the facility and made an on-site visit on 4/29/22, and reported the allegation of misappropriation to the facility's Director of Nursing (DON). The facility human resources department indicated they did not have an employee file for the employee that had exploited Resident #35, therefore there was no evidence that they had conducted pre-hire screening of the employee to determine they were suitable for employment and would not pose a risk to Residents. The facility provided the survey team with a Facility Reported Incident (FRI) regarding this allegation of misappropriation. It was dated 5/2/22. The facility didn't report the allegation to the state survey agency or law enforcement until 4 days after they were made aware of the allegation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/22 at 12:06 PM, an interview was conducted with the DON. During this interview the DON confirmed that APS had notified her of the allegation. The DON stated, I was here and the lady from APS wanted to see me, she said she had an allegation that one of our staff was involved with Resident's money going missing. She had a list of documents she wanted, I gave her those documents and she left. I called the Administrator and when she came back she took over the investigation. The DON was shown the Facility Reported Incident (FRI) that was dated 5/2/22. The DON said, I am aware of the FRI reporting requirements and we have to report abuse but the ED [executive director/administrator] handles that. When asked who is in charge in the absence of the Administrator, the DON said, If the ED is on vacation I can assume that role. If they are just out for the day, I called them and they do it. On 9/15/22 at 6 PM, during an end of day meeting, the facility Administrator was interviewed. The Administrator stated that a FRI (Facility Reported Incident) is completed for anything causing harm, potential harm, or when something happens to a patient, a patient to patient situation or staff to patient. We report the FRI and send to the OLC and APS via fax and the Ombudsman. The initial notification is within 2 hours, we make sure the Resident is safe and start an investigation. Within 5 days we report to the OLC our investigation and what we found out as well as the resolution. On 9/22/22 at 9:39 AM, an interview was conducted with Employee E, the social worker. Employee E stated, If you have an allegation of abuse you have to report it immediately because it has to be reported to the state, APS, and Ombudsman within 2 hours. Also, you need to make sure the Resident is safe during that time, if you don't report immediately you can put the Resident at risk. When asked about the timing of the investigation, Employee E said, Everything has to be done in 5 days. The facility policy titled, Abuse, Neglect and Exploitation Policy was received and reviewed. This policy read, . VII. Reporting and Response: VIRGINIA. i. Within 24 hours of learning of an incident the facility must report it to the OLC unless the incident is an allegation of abuse or involves serious bodily injury and then the facility must report to the OLC within 2 hours. Incidents shall be submitted to the OLC Complaint Department via fax at [fax number redacted]. ii. Any incident or event with a suspicion of a crime is to be reported to the local police department within 2 hours NOTE: Absence of the facility administrator, or designated alternate, from the facility cannot be used to delay implementation of the facility investigation protocols . On 9/15/22 at 6 PM, and again on 9/21/22, during end of day meetings the facility Administrator, Director of Nursing and Corporate staff were made aware the survey team had identified concerns regarding the implementation of their abuse policy. No further information was received. 2. For Resident #117, 31, 84, 367, 369, and 19, the facility staff failed to implement their abuse policy with regards to identifying concerns/reports as allegations of abuse, take measures to protect the Resident(s), conduct an investigation and report the allegation(s). A. On 9/15/22, the survey team discovered that on 5/27/22, Resident #117's family reported to facility staff that assigned CNA was rough while providing perineal care and washing her . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility was asked to provide all Facility Reported Incidents (FRI's) and there was no FRI on file for the allegation reported 5/27/22, involving Resident #117. Review of the facility provided documents revealed the facility completed a grievance form on 5/27/22, and indicated on the form that that Administrator, Director of Nursing, and Social Services Director were notified. There is no evidence that the facility staff identified this as an allegation of abuse, took any measures to protect the Resident, conducted any investigation or reported the allegation as identified in their abuse policy. B. On 9/15/22, the survey team discovered that Resident #31 reported that a CNA [name redacted] was rough during ADL's [activities of daily living] and keep washing and washing her and it is rough on her skin [sic]. Following this report from the Resident, the facility completed a concern form dated 6/10/22. There is no evidence that the facility staff identified this as an allegation of abuse, took any measures to protect the Resident, conducted any investigation or reported the allegation as identified in their abuse policy. C. On 8/3/22, the facility staff identified that the narcotic count was off for Residents #84, 367, 369 and 19. The facility completed a Facility Reported Incident form, however on the form they indicated that physician notification was N/A [not applicable] and the APS (Adult Protective Services) area was blank with no indication of them being made aware. In the course of the facility investigation they identified a staff member as a suspect and included a report form to the Department of Health Professions (licensing board for nurses) but failed to sign the form and gave no indication/evidence that they were notified of the findings and investigation. D. During the Resident and Family interviews conducted by the facility staff on 9/16/22, Resident #62 was asked, Has a staff, a resident or anyone else here abused you? Resident #62 said, Yes, verbally. The facility staff failed to respond to this allegation of abuse. On 9/20/22 at 12:45 PM, the facility staff were made aware that an allegation of abuse had been reported that they had failed to respond to. On the afternoon of 9/20/22, the facility staff submitted documents to the survey team that indicted the interview conducted with Resident #62 had been changed to indicate that no abuse was reported. This was brought to the attention of the facility Administrator, Director of Nursing and Corporate staff, with no explanation being afforded. On 9/21/22 at 11:35 AM, the facility presented additional documentation, which included a Facility Reported Incident that was completed on 9/20/22 regarding Resident #62's allegation. The facility failed to identify and respond timely to a report of abuse, report the allegation and initiate an investigation as per their abuse policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. During a family interview conducted by facility staff on 9/17/22, the family of Resident #31 reported, A few weeks ago a man came in her room at night and he yelled at her. On 9/20/22 at 12:45 PM, the facility staff were made aware that an allegation of abuse had been received and they failed to respond to it. On 9/20/22 at 4:30 PM, the facility provided a Facility Reported Incident that was completed on 9/20/22 regarding Resident #31's allegation. The facility failed to identify and respond timely to a report of abuse, report the allegation and initiate an investigation as per their abuse policy. On 9/15/22 at 6 PM, during an end of day meeting, the facility Administrator was interviewed. The Administrator stated that a FRI (Facility Reported Incident) is completed for anything causing harm, potential harm, or when something happens to a patient, a patient to patient situation or staff to patient. We report the FRI and send to the OLC and APS via fax and the Ombudsman. The initial notification is within 2 hours, we make sure the Resident is safe and start an investigation. Within 5 days we report to the OLC our investigation and what we found out as well as the resolution. On 9/22/22 at 9:39 AM, an interview was conducted with Employee E, the social worker. Employee E defined abuse as, It can be physical, mental, sexual, confinement, misappropriation of Resident's finances or property. Neglect was defined as, Failure to provide services. Employee E stated, If you have an allegation of abuse you have to report it immediately because it has to be reported to the state, APS, and Ombudsman within 2 hours. Also, you need to make sure the Resident is safe during that time, if you don't report immediately you can put the Resident at risk. When asked about the timing of the investigation, Employee E said, Everything has to be done in 5 days. The facility policy titled, Abuse, Neglect and Exploitation Policy was received and reviewed. This policy read, . 4. An employee who is alleged or accused of being a party to abuse, neglect, misappropriation of property will be immediately removed from the area(s) of resident care, interviewed by facility leadership for a written statement and not left alone. 5. After completing the statement(s), the employee(s) will be asked to vacate the facility until further investigation of the incident is completed . The above referenced policy went on to read, .IV. Identification of incidents and allegations. 1. The accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility. 2. The following procedure will assist the staff in the identification of incidents and direct them to appropriate steps of intervention. a. Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect or misappropriation of funds will be identified and reported to the supervisor and investigated timely. b. The supervisor or designee will notify the Director of Nursing and Executive Director allegation immediately. Upon being notified of incident or allegation will direct required notification of agencies, physician, family and resident representative c. The Executive Director will direct the investigation . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section 5 of the policy read, .V. Investigation of Incidents: 1. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow .d. In the event the alleged perpetrator is a staff member that staff member will be removed from areas of resident living and interviewed by nurse on duty. e. The staff member will be escorted off of the premises by another staff member f. The accused staff member will be suspended, by the Executive Director or designee, pending the outcome of the investigation of the incident The above referenced policy went on to say, .2. Alleged violations are reported immediately to the Executive Director of the facility. a. The ED/designee will report appropriate incidents to the Adult Protective Services and the Division of Licensing and Regulation as required by state law. 3. The results of the facility's investigation must be reported to the survey agency, the ED/Designee and other officials in accordance with state law, within five working days of the incident . Pages 18 and 19 of the Abuse policy read, . iii. Facilities must conduct an internal investigation and document their findings for all alleged incidents at the facility within 5 days of the incident. A thorough internal investigation should include, but not limited to: iv. A timely and thorough facility investigation, which is recorded in an investigation report, is critical to substantiate finding of misconduct . Note: Absence of the facility administrator, or designated alternate, from the facility cannot be used to delay implementation of the facility investigation protocols . On 9/16/22 and again on 9/21/22, the facility staff were made aware that they survey team had significant concerns that they failed to identify and respond to allegations of abuse in accordance with regulation requirements and their facility policy. No further information was provided. 40452 3. For Resident #52, the facility staff failed to implement their abuse policy and protect Resident #52 form an alleged perpetrator on 09/13/2022. Also, the facility did not report and adequately investigate the allegation of abuse to the state agency timely. On 09/13/2022 at 11:00 A.M., a Resident Council meeting with 6 Residents was conducted. At 11:18 A.M., the Social Worker entered the Resident Council meeting. When this surveyor asked the social worker why she was entering the meeting, Resident #88 stated he invited the social worker to the meeting. When the other Residents were asked about this, the other Residents in attendance also indicated they would like the social worker to be present. The meeting resumed and when the Residents were asked if call bells were answered timely, Resident #52 stated that the aides appear angry, not giving good service. Resident #52 also stated staff was yelling at me. Resident #52 also indicated she didn't want to provide names. Resident #52 also stated she had experienced retaliation for reporting issues and did not want to elaborate further at the time of the meeting. Resident #88 also reported experiencing retaliation due to their loved one advocating for their care. When asked about what happened, Resident #88 stated that when he would ask for something, the staff wouldn't do it. Resident #88 also stated that the staff would say his loved one was mean and they would laugh at her. On 09/13/2022 at 12:10 P.M. following the Resident Council meeting, the administrator was notified of findings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/13/2022 at 4:26 P.M., the Administrator entered the conference room to present a packet of documents to the survey team. The top page was a document entitled, F600 Abatement Plan 09/13/2022. The opening sentence documented, The facility failed to protect Residents from abusive behavior from staff i. e yelling at residents. Under the header Identification of Others it was documented, All residents have the potential to be affected by this deficient practice. Interview all residents to identify if similar resident abuse exists. Implement action to protect resident if similar allegation is identified by ED [Executive Director] and DON [Director of Nursing] 9/13/22. Interviews conducted house-wide on residents with BIMS [Brief Interview for Mental Status] 12 or greater related to abuse by ED and DON and SW [Social Worker] 9/13/22. Skin assessments conducted house-wide on those with BIMS [Brief Interview for Mental Status] less than 12 UM [unit manager] and DON 9/13/22. Under the header Education the following excerpts were documented: Educate all staff .to organization abuse prevention policies, behavior management, and one on one care guidelines by ED and DON or designee 9/13/22. Facility Leadership team to conduct daily ambassador rounds and interviews to assure residents with potential for abuse, behavioral concerns, and requiring one to one guidelines are identified, investigation initiated, and reported to the state agency timely per guidelines by Designee/ED and SW ongoing. Under the header System Change the following excerpts were documented: Education will be provided to all new employees upon hire and annually on the Abuse policy, behavior management guidelines by HR [Human Resources]. All supervisors will be educated on the process of dealing with difficult behaviors, and when/if a resident complains of any form of abuse, or any abuse is witnessed, staff will notify supervisor immediately and supervisor to inform ED, DON, and MD [Medical Doctor]. There were 14 pages of in-service sheets in the packet of documents with a date range of 06/20/2022 through 09/13/2022 on various topics to include abuse and neglect. There was no evidence in the packet that the allegation of abuse reported on 09/12/2022 by Resident #52 was reported to the state agency or an investigation initiated. On 09/14/2022, Resident #52's clinical record was reviewed. Resident #52's Minimum Data Set with an Assessment Reference Date of 07/27/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 10 out of possible 15 indicative of moderate cognitive impairment for that 7-day look-back period. On 09/15/2022 at 1:00 P.M., a copy of the Facility-Reported Incident (FRI) related to Resident #52's allegation of abuse on 09/13/2022 was requested from the administrator. The Administrator stated a grievance form was filed and an investigation was started. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/15/2022, the facility staff provided a document dated 09/13/22 entitled, Concern Form for Resident #52. Under the header Description of Concern it was documented, Resident verbalize [sic] staff yells at her. Under the header Actions to resolve the concern documented, Social Services interviewed all residents w/a [with a] BIMS [Brief Interview for Mental Status] score of 12 and above with no concerns voiced of verbal, physical, or sexual abuse. The document was signed by the Social Worker on 09/14/2022 and the Administrator on 09/15/2022. On 09/15/2022 at 6:25 P.M., the Administrator was interviewed. When asked about the process for allegations of verbal abuse, the Administrator stated that staff would put a note in the system and it would be investigated and reported initially to the state agency within 2 hours and a follow-up report would be sent to the state agency in 5 days. When asked about a FRI regarding Resident #52's allegation of verbal abuse, the administrator stated a FRI was not done. The facility staff provided a copy of their policy entitled, Abuse, Neglect, and Misappropriation. In Section (IV)(2)(a), it was documented, Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect, or misappropriation of funds will be identified and reported to the supervisor and investigated timely. In Section (V)(1), it was documented, In the event a situation is identified as abuse, neglect, or misappropriation, an investigation by the executive leadership will immediately follow. In Section (V)(2)(a), it was documented, The ED [executive director]/designee will report appropriate incidents to the Adult Protective Services and Division of the Licensing and Regulation as required by state law. 34894 4. For Resident # 217, the facility staff failed to implement the policies on abuse/neglect Resident # 217 was admitted to the facility on [DATE] for skilled services in nursing and therapy with the diagnoses of, but not limited to, Asthma, Congestive Heart Failure (CHF), Chronic Kidney Disease Stage 3, Hypertension, Atrial Fibrillation, Obstructive Sleep Apnea (OSA), Infection due to Multi-resistant organism and Morbid Obesity with BMI (Body Mass Index) 60-69. Review of the Resident # 217's closed clinical record revealed the most recent MDS (Minimum Data Set) was a Quarterly Assessment with an ARD (Assessment Reference Date) of 9/16/2021. The MDS coded Resident #217 as requiring extensive to total assistance of one to two staff persons with activities of daily living and frequently incontinent of bowel and bladder. Review of the closed clinical record was conducted on 9/12/2018 through 9/22/2022. Review of the Progress Notes revealed documentation of a nurses note dated 5/28/2020 at 8:19 a.m. which stated: Resident The CNA (Certified Nursing Assistant) and I transferred (gender redacted) to the wheelchair. At around 10:30 p.m., I asked the CNA to help put (gender redacted) back to bed because it would be difficult if nobody is around to put (gender redacted) to bed. Resident refused to go to bed. (gender redacted) later on asked to be put to bed and I said (Resident # 217's name redacted) not by myself. I will need someone to help me. There was nobody at the moment and (gender redacted) was in the wheelchair for a while until when (Name of CNA redacted) came to help with (name of another resident redacted), then we put (gender redacted) to bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Administrator on 9/21/2022 regarding reporting the allegation of neglect for Resident # 217. The Administrator stated that he had not been aware of documentation in the nurses progress note until the surveyor informed the Regional Consultant about it the day before. He stated he searched but could not find any documentation that the allegation of neglect had been reported to the State Agency by the previous administrator so he completed the FRI (Facility Reported Incident). Review of the FRI showed the incident happened on 5/18/2020 and was reported on 09/21/2022 by the administrator. Review of the FRI (Facility Reported Incident submitted to the state agency on 09/21/2022 reported an allegation (none of the categories describing the type of incident were checked) that occurred on 5/18/2020 . The FRI stated resident asked to put her in bed but staff refused to do so. Staff told the resident not by myself and left the resident in the chair a while. Later another staff came to help. The FRI also stated Employees no longer here under Employee Action Initiated or Taken section. The nurse, LPN (Licensed Practical Nurse) K, failed to assist Resident # 217 back to bed. Resident # 217 had gotten up earlier in the shift due to experiencing Shortness of Breath and difficulty breathing. LPN K was no longer employed at the facility at the time of the survey when the nurses note was discovered. The CNA mentioned in the note also was no longer employed at the facility. The DON stated that she would report to the state agency immediately but no later than 2 hours after the allegation is made. The facility abuse policy Abuse: Prohibition, Reporting, and Investigation of Resident Abuse, Neglect, And Mistreatment was reviewed. Page 3, bullet 5 read As soon as possible, but within no more than twenty-four (24) hours of the suspected abuse, neglect or mistreatment, the Administrator shall notify the Office of Health Care Quality and the local police department (as appropriate) of the suspected abuse, neglect or mistreatment. Both stated that no other information was able to be found. The Administrator and DON were not employed at the facility at the time of the allegation of Neglect. No further information was provided. 40026 5. For Resident # 21 the facility staff failed to implement the abuse policy. On 5/1/22 the facility submitted a FRI (Facility Reported Incident) to the OLC (Office of Licensure and Certification) regarding an allegation of abuse of Resident #21 by LPN F. The FRI read: Describe incident, including location, and action taken: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA [name redacted] reported seeing a male nurse, [name redacted] hit Resident from behind the privacy curtain in room [ROOM NUMBER]. Resident was assessed w/o [without] injury. Employee action initiated or taken - [Employee name redacted] placed on suspension 5/1/22 pending investigation. The investigation contained a statement from the CNA that witnessed the incident. The CNA stated in her witness statement, that she went downstairs upset and was told that they would notify the DON however the CNA stated she did not trust the DON due to hearing her say Stuff like that does not happen on my floor. The CNA went outside and called the police to report the abuse and that the police came and took her statement. A review of the payroll account revealed that the LPN F was not placed on suspension. He worked 5/1/22 through 5/5/22. LPN F continued at the facility as an active employee until 9/16/22 when he was terminated. A review of the employee file included the license verification completed on hiring the nurse. LPN F's license read: Additional Public Information - YES [Please note when YES comes up on a license verification it is indicative of the licensee being brought before the Board of Nursing, and the facility either neglected to click the Yes to find out what the further information was or they checked it and chose to hire the LPN anyway.] The facility had no evidence that they had checked to see what that further information was until after this incident took place. During the course of their investigation they found that LPN F had been terminated from 2 previous facilities for negligence and verbal abuse. A review of the Abuse Neglect and Exploitation Policy # NS 1019-01-VA read: Page 10 4. License / registry check will also be performed as applicable after the interview to verify: a. The Nurse Aide Registry b. The State Board of Nursing c. Other Professional Registries. 6. This facility will NOT employ individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of abuse, neglect, mistreatment of residents or misappropriation of resident's property. The nurse was terminated from employment on 9/16/22. On 9/16/22 the Administrator was made aware of the concerns and no further information was provided (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41450 6. The facility staff failed to obtain a criminal background check within 30 days of hire for 13 Employees (Staff #5, #6, #7, #8, #10, #11, #12, #13, #14, #15, #16, #21, and #23). On 9/15/22, Surveyor G reviewed 25 employee records for criminal background checks which revealed the previously listed findings. On 9/20/22, the Human Resources (HR) Director was interviewed and confirmed the findings for the 13 referenced facility staff members. On 9/21/22, the Facility Administrator was informed of the findings. He stated, Criminal background checks are obtained before we hire anyone because we must be certain that our residents are not exposed to people with a criminal history such as abuse of any kind. Review of the facility's policy titled, Abuse, Neglect, and Exploitation Policy-Virginia, revised 10-27-2021, subtitle, Policy, page 9, read, in part, .Furthermore, it is the intent of this facility to employ only properly screened persons as a part of the resident care team by the applicable requirements and subtitle, Procedure, page 9, section I Screening, item 2 read, A criminal background check will be completed to meet state requirements. No further information was provided. 7. The facility staff failed to perform professional license verification to ensure licensed employees held current licensure or certification and to determine if they had been subject to disciplinary action against their professional license as a result of abuse, neglect or mistreatment for 13 Employees (Staff #3, #5, #7, #8, #10, #11, #13, #18, #19, #20, #21, and #23). On 9/15/22, Surveyor G reviewed 19 licensed employee records for professional license verification which revealed the previously listed findings. On 9/20/22, the Human Resources (HR) Director was interviewed and confirmed the findings for the 13 referenced clinical staff members. On 9/21/22, the Facility Administrator was informed of the findings. He stated, We obtain verifications for anyone who holds a professional license, to be sure they are qualified to provide proper care for our residents and that their license is free from any disciplinary actions by the State [licensing board]. Review of the facility's policy titled, Abuse, Neglect, and Exploitation Policy-Virginia, revised 10-27-2021, subtitle, Policy, page 9, read, in part, .Furthermore, it is the intent of this facility to employ only properly screened persons as a part of the resident care team by the applicable requirements. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Also contained within the facility's abuse policy, subtitle, Procedure, page 9, section I Screening, item 4 read, Licensure/registry check will also be performed, as applicable, after the interview to verify: a. The Nurse Aide Registry, b. State Board of Nursing, c. Other professional registries and item 6 read, This facility will not employ individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents, or misappropriate of their property. No further information was provided. 8. The facility staff failed to provide staff abuse/neglect prevention/reporting training for 3 Employees (Director of Nursing, CNA B, and CNA C). On 9/14/22, Surveyor G reviewed 5 employee records for staff training which revealed the previously listed findings. On 9/14/22, the Staff Development Coordinator (SDC) was interviewed and confirmed the findings for the 3 referenced clinical staff members. The SDC stated, All training is done on the computer through Relias training modules, if it [the training] is not on the transcripts that were provided, then it wasn't done. On 9/15/22, the Facility Administrator was informed of the findings, He stated, HR [Human Resources] is responsible for staff compliance with training, it is supposed to be monitored every day but it doesn't appear that it has been happening, all of the staff in the HR department are new so they are not monitoring this [staff training compliance] yet. On 9/15/22, the Human Resources (HR) Director stated, [name redacted, Staff Development Coordinator] handles all staff training including records, I've not been told otherwise. Review of the facility's policy titled, Abuse, Neglect, and Exploitation Policy-Virginia, revised 10-27-2021, subtitle, Policy, page 9, r [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40452 Based on Resident interviews, staff interviews, clinical record reviews, facility documentation review, and in the course of a complaint investigation, the facility staff failed to report allegations of abuse timely for 7 Residents (Resident #52, Resident #117, Resident #31, Resident #84, Resident #367, Resident #369, Resident #19) in a sample size of 60 Residents. The findings included: 1. For Resident #52, the facility staff failed to report the allegation of abuse to the state agency and adult protective services timely. On 09/13/2022 at 11:00 A.M., a Resident Council meeting with 6 Residents was conducted. At 11:18 A.M., the Social Worker entered the Resident Council meeting. When this surveyor asked the social worker why she was entering the meeting, Resident #88 stated he invited the social worker to the meeting. When the other Residents were asked about this, the other Residents in attendance also indicated they would like the social worker to be present. The meeting resumed and when the Residents were asked if call bells were answered timely, Resident #52 stated that the aides appear angry, not giving good service. Resident #52 also stated staff was yelling at me. Resident #52 also indicated she didn't want to provide names. Resident #52 also stated she had experienced retaliation for reporting issues and did not want to elaborate further at the time of the meeting. Resident #88 also reported experiencing retaliation due to their loved one advocating for their care. When asked about what happened, Resident #88 stated that when he would ask for something, the staff wouldn't do it. Resident #88 also stated that the staff would say his loved one was mean and they would laugh at her. On 09/13/2022 at 12:10 P.M. following the Resident Council meeting, the administrator was notified of findings. On 09/14/2022, Resident #52's clinical record was reviewed. Resident #52's Minimum Data Set with an Assessment Reference Date of 07/27/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 10 out of possible 15 indicative of moderate cognitive impairment for that 7-day look-back period. On 09/15/2022 at 1:00 P.M., a copy of the Facility-Reported Incident (FRI) related to Resident #52's allegation of abuse on 09/13/2022 was requested from the administrator. On 09/15/2022 at 6:25 P.M., the Administrator was interviewed. When asked about the process for allegations of verbal abuse, the Administrator stated that staff would put a note in the system and it would be investigated and reported initially to the state agency within 2 hours and a follow-up report would be sent to the state agency in 5 days. When asked about a FRI regarding Resident #52's allegation of verbal abuse, the administrator stated a FRI was not done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/19/2022, the facility staff provided a copy of the FRI dated 09/16/2022 and fax notification documents associated with Resident #52's allegation of verbal abuse on 09/13/2022. The fax notification to the state agency was sent on 09/16/2022 at 9:57 P.M. The notification to Adult Protective Services was sent on 09/16/2022 at 6:44 P.M. This was over three days after the Administrator learned of the allegation of verbal abuse. The facility staff provided a copy of their policy entitled, Abuse, Neglect, and Misappropriation. In Section (VII)(i), an excerpt documented, Within 24 hours of learning of an incident the facility must report it to the OLC [state agency] unless the incident is an allegation of abuse or involves serious bodily injury and then the facility must report to the OLC within 2 hours. 41449 2. For Resident #117, who reported an allegation of abuse, the facility staff failed to report the allegation to the OLC (Office of Licensure and Certification/state survey agency) and Adult Protective Services. On 9/15/22, the survey team discovered that Resident #117's family reported to facility staff that assigned CNA was rough while providing perineal care and washing her . The facility completed a grievance form on 5/27/22, and indicated on the form that that Administrator, Director of Nursing, and Social Services Director were notified. There is no evidence that the facility reported this allegation to the State survey agency or Adult Protective Services nor the results of an investigation. On 9/15/22 at 6 PM, during an end of day meeting, the facility Administrator was interviewed. The Administrator stated that a FRI (Facility Reported Incident) is completed for anything causing harm, potential harm, or when something happens to a patient, a patient to patient situation or staff to patient. We report the FRI and send to the OLC and APS via fax and the Ombudsman. The initial notification is within 2 hours, we make sure the Resident is safe and start an investigation. Within 5 days we report to the OLC our investigation and what we found out as well as the resolution. On 9/22/22 at 9:39 AM, an interview was conducted with Employee E, the social worker. Employee E stated, If you have an allegation of abuse you have to report it immediately because it has to be reported to the state, APS, and Ombudsman within 2 hours. Also, you need to make sure the Resident is safe during that time, if you don't report immediately you can put the Resident at risk. When asked about the timing of the investigation, Employee E said, Everything has to be done in 5 days. The facility policy titled, Abuse, Neglect and Exploitation Policy was received and reviewed. This policy read, . V. Reporting of Incidents and Facility Response: 1. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. a. If the events that cause the allegation do not result in serious bodily injury, reporting to the administrator and to other reporting regulatory bodies must occur within twenty-four hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above referenced policy went on to say, .2. Alleged violations are reported immediately to the Executive Director of the facility. a. The ED/designee will report appropriate incidents to the Adult Protective Services and the Division of Licensing and Regulation as required by state law. 3. The results of the facility's investigation must be reported to the survey agency, the ED/Designee and other officials in accordance with state law, within five working days of the incident . On 9/15/22 at 6 PM, and again on 9/21/22, during end of day meetings the facility Administrator, Director of Nursing and Corporate staff were made aware the survey team had identified concerns regarding the timing of FRI reporting, the lack of evidence that the appropriate agencies were notified and the lack of evidence of final/5 day reports being made. No further information was received. 3. For Resident #31, the facility staff failed to report to the OLC (Office of Licensure and Certification/state survey agency) and Adult Protective Services an allegation of abuse. On 9/15/22, the survey team discovered that Resident #31 reported that a CNA [name redacted] was rough during ADL's [activities of daily living] and keep washing and washing her and it is rough on her skin [sic]. Following this report from the Resident, the facility completed a concern form dated 6/10/22, and had no evidence of this allegation being reported to the OLC or Adult Protective Services. On 9/15/22 at 6 PM, during an end of day meeting, the facility Administrator was interviewed. The Administrator stated that a FRI (Facility Reported Incident) is completed for anything causing harm, potential harm, or when something happens to a patient, a patient to patient situation or staff to patient. We report the FRI and send to the OLC and APS via fax and the Ombudsman. The initial notification is within 2 hours, we make sure the Resident is safe and start an investigation. Within 5 days we report to the OLC our investigation and what we found out as well as the resolution. On 9/22/22 at 9:39 AM, an interview was conducted with Employee E, the social worker. Employee E stated, If you have an allegation of abuse you have to report it immediately because it has to be reported to the state, APS, and Ombudsman within 2 hours. Also, you need to make sure the Resident is safe during that time, if you don't report immediately you can put the Resident at risk. When asked about the timing of the investigation, Employee E said, Everything has to be done in 5 days. The facility policy titled, Abuse, Neglect and Exploitation Policy was received and reviewed. This policy read, . V. Reporting of Incidents and Facility Response: 1. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. a. If the events that cause the allegation do not result in serious bodily injury, reporting to the administrator and to other reporting regulatory bodies must occur within twenty-four hours. The above referenced policy went on to say, .2. Alleged violations are reported immediately to the Executive Director of the facility. a. The ED/designee will report appropriate incidents to the Adult Protective Services and the Division of Licensing and Regulation as required by state law. 3. The results of the facility's investigation must be reported to the survey agency, the ED/Designee and other officials in accordance with state law, within five working days of the incident . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/22 at 6 PM, and again on 9/21/22, during end of day meetings the facility Administrator, Director of Nursing and Corporate staff were made aware the survey team had identified concerns regarding the timing of FRI reporting, the lack of evidence that the appropriate agencies were notified and the lack of evidence of final/5 day reports being made. No further information was received. 4. The facility staff failed to report an allegation of misappropriation of narcotic medication involving Residents #84, 367, 369, and 19. On 8/3/22, the facility staff identified that the narcotic count was off for Residents #84, 367, 369 and 19. The facility completed a Facility Reported Incident form, however on the form they indicated that physician notification was N/A [not applicable] and the APS (Adult Protective Services) area was blank with no indication of them being made aware. In the course of the facility investigation they identified a staff member as a suspect and included a report form to the Department of Health Professions (licensing board for nurses) but failed to sign the form and gave no indication/evidence that they were notified of the findings and investigation. On 9/15/22 at 6 PM, during an end of day meeting, the facility Administrator was interviewed. The Administrator stated that a FRI (Facility Reported Incident) is completed for anything causing harm, potential harm, or when something happens to a patient, a patient to patient situation or staff to patient. We report the FRI and send to the OLC and APS via fax and the Ombudsman. The initial notification is within 2 hours, we make sure the Resident is safe and start an investigation. Within 5 days we report to the OLC our investigation and what we found out as well as the resolution. On 9/22/22 at 9:39 AM, an interview was conducted with Employee E, the social worker. Employee E stated, If you have an allegation of abuse you have to report it immediately because it has to be reported to the state, APS, and Ombudsman within 2 hours. Also, you need to make sure the Resident is safe during that time, if you don't report immediately you can put the Resident at risk. When asked about the timing of the investigation, Employee E said, Everything has to be done in 5 days. The facility policy titled, Abuse, Neglect and Exploitation Policy was received and reviewed. This policy read, . V. Reporting of Incidents and Facility Response: 1. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. a. If the events that cause the allegation do not result in serious bodily injury, reporting to the administrator and to other reporting regulatory bodies must occur within twenty-four hours. The above referenced policy went on to say, .2. Alleged violations are reported immediately to the Executive Director of the facility. a. The ED/designee will report appropriate incidents to the Adult Protective Services and the Division of Licensing and Regulation as required by state law. 3. The results of the facility's investigation must be reported to the survey agency, the ED/Designee and other officials in accordance with state law, within five working days of the incident . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/22 at 6 PM, and again on 9/21/22, during end of day meetings the facility Administrator, Director of Nursing and Corporate staff were made aware the survey team had identified concerns regarding the timing of FRI reporting, the lack of evidence that the appropriate agencies were notified and the lack of evidence of final/5 day reports being made. No further information was received. Complaint related deficiency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on Resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to investigate allegations of abuse, exploitation and mistreatment, and failed to take measures to protect residents, and failed to make corrections affecting 4 Residents (Resident #35, 368, 52, and 317) in a survey sample of 60 Residents. The failure to make corrections resulted in harm for Residents #35 and #368. The findings included: 1. For Residents #35 and #368, who were married and victims of financial misappropriation and were exploited for an excess of $50,000, the facility staff failed to make corrections/restitution, which resulted in fear of economic hardship and mistrust, which constituted harm. On 9/12/22 at 3:07 PM, an interview was conducted with Resident #35. Resident #35 said, I had trouble when I first came here, thieves got hold of the books and it was a minor thing to them. I woke up one morning and the checking account was down to zero. It was an inside job, no one cared about how the books were managed. I would rather go home and do the best we can versus stay here and go broke. When asked if he worries about the ability to pay for continued care, Resident #35 said, Yes. On 9/15/22 at 4 PM, a follow-up interview was conducted with Resident #35. He stated, $70,000 was taken. We used a check to pay the facility because it wasn't covered by Medicare, we wrote a check for the amount due and they never paid the business office. Another check was written and they went to a young teller and got the money and we were down to zero. When asked how did this make him feel, Resident #35 said, [Expletive], I will be blunt. My wife is starting to get tarnished in her trust in people. I want to get out of here because of how they run their accounting and they see nothing wrong with it. It all started here, $4,000 my wife paid was charged to us again, and then another $5,000, looks like the hands of thieves are in it again. On 9/21/22 at 9:54 AM, an interview was conducted with Resident #368. When asked about the incident, Resident #368 said, I'm not sure who took it. A lady there released me and she wanted over $5,000 from me and never took it to the business office. They stole all our money. I'm having so much trouble with that business office. Resident #368 confirmed she feels taken advantage of. The interview was terminated because Resident #368 became very upset and tearful and said, I don't like what is going on. A lot of nights I lay awake and can't sleep, it's awful I sit here and cry a lot. Now I have to worry about money all the time. On 9/15/22, an interview was conducted with Adult Protective Services (APS). They were able to provide information regarding their investigation which revealed a preponderance of evidence to substantiate that Residents #35 and 368 were victims of financial exploitation by a facility employee in excess of $50,000. Their investigation was turned over to financial crimes department with the police. On 9/15/22, an interview was conducted with the investigator from the police department. He stated, Based on the evidence of the investigation thus far, we are able to determine a crime did take place and Residents #35 and 368 were victims of misappropriation and exploitation by an employee of the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Few	On 9/15/22, during an interview with Adult Protective Services (APS), Surveyor B was notified that APS had called the facility and made an on-site visit on 4/29/22, and reported the allegation of misappropriation to the facility's Director of Nursing (DON). The facility provided the survey team with a Facility Reported Incident (FRI) that was completed on 5/2/22, regarding this allegation of misappropriation. On 9/13/22, 9/15/22, and again on 9/16/22, the facility Administrator was asked to provide all documentation regarding this FRI, investigation, etc. Review of the facility reported incident/investigation revealed an investigation follow-up letter dated 5/4/22. This letter/report indicated that Resident #35 and 368's bank fraud department is how the concerns of fraud were identified and the bank reported the concerns to Resident #368. The report further stated that the facility was cooperating with the police department's investigation. There was no indication that any conclusion was made in the facility level investigation, nor that any correction/restitution had been made to Residents #35 and #368 to alleviate their duress. The facility policy titled, Abuse, Neglect and Exploitation Policy was received and reviewed. This policy did not address the facility's obligation to make amends to Residents who are victims of financial exploitation and misappropriation. On 9/21/22, during end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware the survey team had concerns regarding the facility not making corrections/restitution to Residents #35 and #368 with regards to the money that was misappropriated, which caused ongoing duress to the Residents. No further information was received. 40452 2. For Resident #52, the facility staff failed to adequately investigate the allegation of abuse on 09/13/2022. On 09/13/2022 at 11:00 A.M., a Resident Council meeting with 6 Residents was conducted. At 11:18 A.M., the Social Worker entered the Resident Council meeting. When this surveyor asked the social worker why she was entering the meeting, Resident #88 stated he invited the social worker to the meeting. When the other Residents were asked about this, the other Residents in attendance also indicated they would like the social worker to be present. The meeting resumed and when the Residents were asked if call bells were answered timely, Resident #52 stated that the aides appear angry, not giving good service. Resident #52 also stated staff was yelling at me. Resident #52 also indicated she didn't want to provide names. Resident #52 also stated she had experienced retaliation for reporting issues and did not want to elaborate further at the time of the meeting. Resident #88 also reported experiencing retaliation due to their loved one advocating for their care. When asked about what happened, Resident #88 stated that when he would ask for something, the staff wouldn't do it. Resident #88 also stated that the staff would say his loved one was mean and they would laugh at her. On 09/13/2022 at 12:10 P.M. following the Resident Council meeting, the administrator was notified of findings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Few	On 09/14/2022, Resident #52's clinical record was reviewed. Resident #52's Minimum Data Set with an Assessment Reference Date of 07/27/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 10 out of possible 15 indicative of moderate cognitive impairment for that 7-day look-back period. On 09/15/2022 at 1:00 P.M., a copy of the Facility-Reported Incident (FRI) related to Resident #52's allegation of abuse on 09/13/2022 was requested from the administrator. The Administrator stated a grievance form was filed and an investigation was started. On 09/15/2022, the facility staff provided a document dated 09/13/22 entitled, Concern Form for Resident #52. Under the header Description of Concern it was documented, Resident verbalize [sic] staff yells at her. Under the header Actions to resolve the concern documented, Social Services interviewed all residents w/a [with a] BIMS [Brief Interview for Mental Status] score of 12 and above with no concerns voiced of verbal, physical, or sexual abuse. The document was signed by the Social Worker on 09/14/2022 and the Administrator on 09/15/2022. There were no other documents provided associated with the allegation of verbal abuse made on 09/13/2022. On 09/15/2022 at 6:25 P.M., the Administrator was interviewed. When asked about the process for allegations of verbal abuse, the Administrator stated that staff would put a note in the system and it would be investigated and reported initially to the state agency within 2 hours and a follow-up report would be sent to the state agency in 5 days. When asked about a FRI regarding Resident #52's allegation of verbal abuse, the administrator stated a FRI was not done. The facility staff provided a copy of their policy entitled, Abuse, Neglect, and Misappropriation. In Section (IV)(2)(a), it was documented, Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect, or misappropriation of funds will be identified and reported to the supervisor and investigated timely. In Section (V)(1), it was documented, In the event a situation is identified as abuse, neglect, or misappropriation, an investigation by the executive leadership will immediately follow. In Section (VII)(iv)(v), it was documented, A timely and thorough investigation, which is recorded in an investigation report, is critical to substantiate finding of misconduct. An investigative report provides: a record of the facility investigators activities in findings so that nothing is left a memory; a permanent official record of the facility investigators actions, observations and discoveries; a basic reference of the case; information on what is been done concerning the case; a basis for deciding further action; a method to communicate the findings of the case; and information that can be evaluated to detect and identify patterns of misconduct. Investigative reports should contain the following basic elements: individuals involved, i.e. all persons connected in any way with the incident under investigation such as, residents, complainant, suspected individual, witnesses, any other with first-hand knowledge. Individuals should be identified in such a manner that they cannot be confused with any other individuals; description of the incident in a precise and accurate manner; including observable facts and statements from witnesses; time and date of the incident; specific location of all persons and things related to the incident, including room numbers, wing/corridor locations, objects in the space, noise, furnishings, clothing of victim; and effect on the resident or resident's reaction. 3. For Resident #317, the facility staff failed to adequately investigate the allegation of abuse on 12/15/2021. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Few	On 09/22/2022 at approximately 8:35 A.M., in the course of a complaint investigation, a Facility-Reported Incident (FRI) for Resident #317 dated 12/14/2021 was requested from the Administrator. The incident was pertaining to an allegation of abuse from Certified Nursing Assist S (CNA S) in December 2021. On 09/22/2022 at 9:15 A.M., the Human Resources Manager was interviewed. The Human Resources Manager verified that CNA S was still an active employee but currently suspended pending an investigation. When asked what the investigation was about, the Human Resources Manager stated that it was a complaint from a Resident of the aide being rough with the Resident. The Resident was identified and placed in the sample as Resident #84. When asked if there were any disciplinary actions in her file, the Human Resources Manager searched through her file and stated that there were no disciplinary actions in her file. On 09/22/2022 at approximately 9:35 A.M., a copy of the current FRI involving CNA S was requested from the administrator. On 09/22/2022 at 11:05 A.M., the Administrator provided a FRI pertaining to Resident #317 dated 12/15/2021 and a document entitled, FRI Investigation Summary. When asked about the investigation supporting documents such has Resident assessment, staff and resident interviews, witness statements, and reporting fax receipts to state agencies, the Administrator that he would look for them but This is all we have here. There were no evidence an adequate investigation was completed. On the FRI document dated 12/15/2021 under the header Describe incident, including location, and action taken: it was documented, Writer was made aware today that resident's daughter had concerns about nursing care and unprofessional behavior of a particular nursing employee. This employee was named on the FRI document and placed in the staff identifier as Certified Nursing Assistant S (CNA S). On the document FRI Investigation Summary dated 12/20/2021 under the header Summary of Investigation documented, Daughter stated during the follow-up meeting that Nursing Assistant (CNA S) displayed negative behavior towards her and the care of her father. During interview with the employee, she reported that she had changed the resident that day but had no interaction with the daughter. Accused employee has been at [facility name] since April 2017 with no record of any conduct or performance issues. Social Services Director conducted interviews with fourteen (14) A&O [alert and oriented] residents assigned to this employee. None shared any negative comments regarding employee conduct. Under the header Conclusion, an excerpt documented, The accused employee conducted herself in an unprofessional and negative manner, toward either the daughter or the resident, could not be substantiated. However, the employee will not be assigned to this resident per daughter's request when she returns to work. On 09/22/2022 at 11:30 A.M., the Administrator provided a copy of the current FRI dated 09/16/2022 involving Resident #84 and CNA S. Under the header, Describe incident, including location, and action taken: it was documented, The resident indicated that the CNA grabbed him aggressively from the behind. The resident does not remember the exact date or time. A head to toe assessment for the resident was conducted and no new findings. Social worker will continue to monitor resident and psych referral made. There was no evidence an investigation was completed, no supporting documents, and no five-day follow-up report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Few	On 09/22/2022 at approximately 11:45 A.M., Resident #84's clinical record was reviewed. Resident #84 was initially admitted to the facility on [DATE]. Resident #84's quarterly Minimum Data Set with an Assessment Reference Date of 08/15/2022 coded the Brief Interview for Mental Status as 15 out of 15 indicative of intact cognition. The facility staff provided a copy of their policy entitled, Abuse, Neglect, and Misappropriation. In Section (IV)(2)(a), it was documented, Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect, or misappropriation of funds will be identified and reported to the supervisor and investigated timely. In Section (V)(1), it was documented, In the event a situation is identified as abuse, neglect, or misappropriation, an investigation by the executive leadership will immediately follow. In Section (VII)(iv)(v), it was documented, A timely and thorough investigation, which is recorded in an investigation report, is critical to substantiate finding of misconduct. An investigative report provides: a record of the facility investigators activities in findings so that nothing is left a memory; a permanent official record of the facility investigators actions, observations and discoveries; a basic reference of the case; information on what is been done concerning the case; a basis for deciding further action; a method to communicate the findings of the case; and information that can be evaluated to detect and identify patterns of misconduct. Investigative reports should contain the following basic elements: individuals involved, i.e. all persons connected in any way with the incident under investigation such as, residents, complainant, suspected individual, witnesses, any other with first-hand knowledge. Individuals should be identified in such a manner that they cannot be confused with any other individuals; description of the incident in a precise and accurate manner; including observable facts and statements from witnesses; time and date of the incident; specific location of all persons and things related to the incident, including room numbers, wing/corridor locations, objects in the space, noise, furnishings, clothing of victim; and effect on the resident or resident's reaction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, clinical record review, and facility record review, the facility staff failed for 1 resident (Resident #119) to provide the resident with a necessary and safe discharge, in a survey sample of 60 Residents. The Findings included: The facility unnecessarily, and unsafely discharged Resident #119, did not apply for timely insurance coverage for a needed continuance of stay, and further failed to involve, evaluate, and provide Resident #119 with an interdisciplinary discharge plan. No community services were planned, no written discharge instructions were planned, nor given to the Resident, no medical equipment was obtained for discharge home, and the facility did not document a recapitulation of the Resident's stay in the clinical record. Resident #119 was admitted to the facility on [DATE] and discharged home on 7-8-22 (6 weeks later). Resident #119's diagnosis included; Heart disease, Heart Failure, Diabetes, chronic kidney disease, stroke, obesity, a sacral pressure sore, and hypertension. The most recent Minimum Data Set (MDS), which was a 30-Day Assessment was reviewed and coded Resident #119 as having intact cognition. The Resident was his own responsible party. On 9-21-22, a review was conducted of Resident #119's clinical record. The Resident discharged home on 7-8-22. There was no record of discharge planning, no discharge plan completed in the care plan nor in the therapy notes, and the doctor and therapists were notified after the Resident was discharged that he had been discharged . The last nursing progress note prior to discharge was written by the day shift nurses on 7-7-22 at 1:40 PM, and 2:30 p.m., stating that the Resident had changed rooms (no documented reason was given), and that no new skin issues were assessed, and healed. The Resident had 2 pressure areas which were not healed. No location for the nursing assessment of healed, was given. On 9-21-22 Physical therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) notes were reviewed and revealed that on 7-7-22 Resident #119 has progressed with all 3 therapies and improvements were noted, however, the Resident required more time in therapy to reach the goals to move home safely. The Resident required minimal assistance with dressing, moderate assistance with toileting, contact guard assist with transferring to a toilet from a wheel chair using a scooting/bridging/sliding technique with a walker. The Resident was receiving therapy instruction on safe techniques with adaptive equipment for bed mobility, balance, energy conservation, safety in transitional movements, and safe use of durable medical equipment that would be needed/ordered upon discharge. The Resident was documented as continuing to have difficulty with peri care (incontinence care). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7-7-22 the therapy evaluations stated that continued therapy was needed to reach goals of limited assistance needed at home, and were recommended to be continued 5 times per week, for 4 more weeks to meet goals to return home. The Resident lived alone and had only Friends who lived 30-35 minutes away from the Resident and would only be Stopping by at times to assist. The Resident was documented as stating that when a date for discharge was planned he would contact his middle son to fly in from California to assist him upon his discharge. This indicated that home health would also be necessary upon discharge. The projected insurance date for discharge at that time was 7-14-22, and another application to the Resident's insurance would be needed to extend his Rehab time. No further therapy nor insurance communication was documented by the facility regarding this Resident and an interview with the Social Worker was requested by surveyors. On 9-21-22 an interview with the Social worker was conducted and revealed that the Regional Insurance Case Manager for the facility's parent company did not submit for further stay insurance authorization for Resident #119, and he was notified on 7-7-22 that his room would change and he would need to pay for the stay out of pocket as his insurance coverage would end on that very day (7-7-22). The Resident stated he needed home health and medical equipment and he would have to discharge as he was unable to pay out of pocket for the stay. Resident #119 discharged in a Taxi cab he called for himself, without a discharge plan, or home health services, or medical equipment to travel from [NAME] Virginia to Maryland alone on 7-8-22. Facility documents were reviewed and revealed that on 6-30-22 the Regional Insurance Case Manager for the facility's parent company corresponded via email with the Rehabilitation Director, and asked what support the Resident would require as to home health upon discharge. The email was forwarded to the Social Services Assistant who replied that Resident #119 would be moving home alone to Maryland and would need home health services. The Resident stated he would need to be ambulating well so that he could do his stairs safely at home. The resident required (2) 2 wheeled walkers, one for upstairs and 1 for downstairs, a raised toilet seat, a hospital bed, and a wheelchair. The final documentation in the clinical record was written on 7-12-22 (4 days after the Resident discharged) by the Social worker in a progress note which stated the Resident left AMA (against medical advice). The facility policy on discharge (D/C) planning was requested and received. The policy stated the following; The discharge process will begin with 72 hours of admission, planning will involve residents needs for assistance with activities of daily living, meals, ambulation, transportation medications, primary care physician follow up, home health, home care, outpatient/community outreach services. The resident and or their representative will be active participants in the D/C planning process. The plan will be reviewed by the Resident or representative weekly and Social services will update the plan. Within 6 days of discharge the Social Services Department will ensure all portions of the plan are completed, and after completion the plan will be printed and signed by the Resident or representative. A copy of the signed plan will be kept in the medical chart and a copy will be given to the Resident or Resident representative. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no discharge plan completed in the clinical record, there was no discharge plan in the care plan, and no discharge recapitulation of stay was in the clinical record from the physician. The Administrator and Director of nursing were asked for these documents, and stated there are none. On 9-21-22 at the end of day debriefing the facility administration was made aware of the deficient practice. They stated they had nothing further to provide.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to notify the Long Term Care ombudsman of the discharge of one Resident (Resident # 217) in a survey sample of 60 residents and the facility staff failed to notify the Ombudsman of any discharges during a 4 month period of time (October 2021-January 2022). Findings included: 1. For Resident # 217, the facility staff failed to notify the Ombudsman of the transfer to the hospital on 11/16/2021. The facility staff did not notify the Ombudsman of any discharges in October 2021 to January 2022. Resident # 217 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Asthma, Congestive Heart Failure (CHF), Chronic Kidney Disease Stage 3, Hypertension, Atrial Fibrillation, Obstructive Sleep Apnea (OSA), Infection due to Multi-resistant organism and Morbid Obesity with BMI (Body Mass Index) 60-69. The MDS coded Resident #217 as requiring extensive to total assistance of one to two staff persons with activities of daily living and frequently incontinent of bowel and bladder. On 9/ 14/2022 an interview was conducted with the Social Services Director who stated Notices of discharges should be sent to the Ombudsman's office at least monthly. The Social Services Director stated that she usually would send the notices a least once a month but sent them more often depending upon how many discharges there were during that month. She stated sometimes I send them every two weeks. When asked for a copy of the Ombudsman notification informing the Ombudsman of Resident # 217 being transferred in November 2017, the Social Worker stated she did not see any verification that the information was sent. When asked for copies of the Ombudsman notifications for October, November and December 2021, the Social Services Director stated she did not see any verification that notices were sent. The Social Services Director stated she started working at the facility in December 2021. A copy of the January 2022 notice was requested. On 9/21/2022 during the end of day debriefing, the facility administrator, Director of Nursing, Social Services Director and Regional Consultants were informed of the findings of no documentation of notices being sent to the Ombudsman during October, November and December 2021 and none for January 2022. The Regional Consultant stated we do not have them. They were not done. No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on staff interview, clinical record review and in the course of a complaint investigation, the facility failed to issue an accurate written bed hold notice for 1 resident (Resident #217) of 60 residents in the survey sample. Findings included: For Resident # 217, the Bed Hold Authorization form was signed but incomplete. There were blanks in the documents. Resident # 217 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Asthma, Congestive Heart Failure (CHF), Chronic Kidney Disease Stage 3, Hypertension, Atrial Fibrillation, Obstructive Sleep Apnea (OSA), Infection due to Multi-resistant organism, and Morbid Obesity with BMI (Body Mass Index) 60-69. The MDS coded Resident #217 as requiring extensive to total assistance of one to two staff persons with activities of daily living and frequently incontinent of bowel and bladder. Review of the electronic clinical record was conducted 9/12/2022 - 9/22/2022, including a review of the miscellaneous forms, revealed a document entitled Bed Hold Authorization Form. The document dated 11/16/2021 revealed signatures of the Responsible Party and the facility Social Worker. The form was not completed. There were blank spaces where the amount of the daily rate. An excerpt read: The rate for holding a bed is equal to the prevailing daily rate of _____. This serves as a notice of bed hold days the resident currently has remaining that will be paid by Medicaid:___days . If the resident does not return to the facility within that tine period, you may choose to guarantee the availability of an accommodation by paying privately the daily rate for that accommodation, which is listed above. Otherwise admission to the facility will be on a first available basis. On 9/20/2022 at 11:15 a.m., an interview was conducted with the Regional Nurse Consultant who stated the facility staff should have completed the information informing the resident/responsible party of the amount of the daily rate and the remaining days that would be paid by Medicaid. The Regional Nurse Consultant stated the resident and/or Responsible party should not be asked to sign forms that are not complete. During the end of day debriefing on 9/21/2022, the facility Administrator, Director of Nursing, Regional Nurse Consultant and Corporate vice President were informed of the findings. The Administrator and Regional Nurse stated the Bed Hold forms should be completed properly prior to having the Resident and/or Responsible Party sign so they would know their responsibility. No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 34894 Based on staff interview, facility documentation review, clinical record review,and in the course of a complaint investigation, the facility staff failed to ensure an accurate MDS/RAI assessment was completed for one resident (Resident #217) in a survey sample of 60 residents. Findings included: 1. For Resident # 217, the facility staff failed to complete Section C: Cognitive Patterns in a Quarterly assessment dated [DATE]. Resident # 217 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Asthma, Congestive Heart Failure (CHF), Chronic Kidney Disease Stage 3, Hypertension, Atrial Fibrillation, Obstructive Sleep Apnea (OSA), Infection due to Multi-resistant organism, and Morbid Obesity with BMI (Body Mass Index) 60-69. Review of the clinical record was conducted on 9/12/2022-9/22/2022. Review revealed the most recent MDS (Minimum Data Set) assessment was a Quarterly Assessment with an ARD of 9/16/2021. Review of Section C for Cognitive Patterns revealed Section C0100 asked the question if a Brief Interview for Mental Status (Section C0200-C0500) be conducted. The facility staff answered yes. Further review of the MDS revealed dashes in several sections in Section C for Cognitive Patterns. Sections C0200-C0500 were documented as not assessed. The next section C0600- Should staff assessment be conducted? not assessed. C0700-Short Term Memory- not assessed. C0800-Long Term Memory-not assessed. C0900- Memory Recall Ability- Staff answered no to all of the questions regarding A. Current Season, B. location of own room, C. staff names and faces, and D. that he or she is in a nursing home . and Z. none of the above recalled. C1000- Cognitive Skills for Daily Decision Making-not assessed. Review of the MDS Annual Assessment with an ARD of 12/24/2020 revealed Section C was completed and Resident # 217 was coded with a BIMS score of 15 indicating no cognitive impairment. Throughout the clinical record in the nurses progress notes and physicians progress notes, there was documentation that Resident # 217 was alert and oriented x 3 (person, place and time). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/14/2022 at 2:10 p.m., an interview was conducted with the Regional Nurse Consultant who stated the entire MDS should be completed. The Regional Nurse Consultant stated the MDS was an important assessment tool. She stated the section on Cognition was important to determine if there was any cognitive impairment and would help to guide the care plan. On 9/14/2022 at 2:20 p.m., an interview was conducted with the MDS Coordinator who stated it was important to complete all sections of the MDS. She stated she did not know why the Section C had not been completed. The MDS Coordinator stated she would review Resident # 217's record to determine what happened. There was no BIMS (Brief Interview for Mental Status Score) calculated due to the assessment not being completed as indicated by the dashes. Guidance was provided in Long Term Care Facility Resident Assessment User's Manual Version 3.0 May 2013, p. C-3. An excerpt read: Steps for Assessment 1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0700 - C1000, Staff Assessment of Mental Status. 2. Review Language item (A1100), to determine if the resident needs or wants an interpreter. If the resident needs or wants an interpreter, complete the interview with an interpreter . Coding Instructions Record whether the cognitive interview should be attempted with the resident. Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status . Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available . Proceed to C0200, Repetition of Three Words. CMS's RAI Version 3.0 Manual CH 3: MDS Items [C] May 2013 Page C-2 . C0100: Should Brief Interview for Mental Status Be Conducted? (cont.) Coding Tips . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, Staff Assessment of Mental Status, instead of C0200-C0500, Brief Interview for Mental Status. Includes residents who use American Sign Language (ASL). C0200-C0500: Brief Interview for Mental Status (BIMS) . Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system. - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed. - Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes . All items for which a dash is not an acceptable value can be found on the CMS MDS 3.0 Technical Information web page at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment- Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html The Administrator, DON (Director of Nursing), and Corporate Consultants were informed of the failure of the staff to complete Section C100-C1000 accurately for a quarterly MDS during the end of day debriefing on 9/21/2022. No further information was provided. COMPLAINT DEFICIENCY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on Observations, Staff interview, and clinical record review, facility staff failed to refer 1 Resident (Resident #77) with a serious mental illness for a level 2 PASARR, in a survey sample of 60 Residents. The findings included: For Resident #77 a PASARR II was not completed despite diagnoses of serious Mental Illness, schizophrenia, Bipolar I & II, delusions, psychosis, Cyclothymic disorder, psychotic disorder, behaviors, and behavior management. Resident #77 was readmitted on [DATE]. Diagnoses included the above, as well as, Diabetes, Hyperlipidemia, anemia, heart failure and renal insufficiency. The most recent Minimum Data Set (MDS) Assessment was a quarterly Assessment with an Assessment Reference Date (ARD) of 8-12-2020. The Brief Interview for Mental Status scored as 11 of a possible 15, indicating mild cognitive impairment. On 9-15-22, a review of Resident #77's record was conducted. The diagnoses associated with the Resident's serious mental illness were noted. The Director of Nursing (DON) was asked to located Resident #77's Pre-Admission Screening and Resident Review (PASARR) Level I and/or Level II. The DON returned with a PASARR I which was incomplete, and stated that a Level II should have been completed, however, had not been completed. On 9-16-22 at the end of day debrief the Administrator and Director of Nursing were informed of the findings, and stated they had nothing further to provide.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 40026 Based on interview, clinical record review and facility documentation, facility staff failed to ensure PASRR (Pre-admission Screening and Resident Review) prior to admission, for 1 Resident (#34) in a survey sample of 60 Residents. The findings included: For Resident #34 the facility staff failed to ensure a PASRR was completed prior to his admission on 5/23/22. On 9/13/22 a review of the clinical record revealed that Resident #34 did not have a completed PASRR on admission. The Social Worker at the facility completed the PASRR after he arrived at the facility, however, she did not complete the PASRR. The Social Worker completed boxes 1-4 however she did not complete box #5 which is the box that read: Recommendation (either a or b must be checked) She did not check either a (recommending a level 2) or b (stating why a level 2 was not appropriate for this resident). On the morning of 9/15/22 the Social Worker was interviewed and she was asked if the PASRR is complete and she stated that it was not. When asked why it was not filled out completely she stated that she did not know why it was blank. When asked if she signed it she stated that she had. On 9/16/22 during the end of day meeting the Administrator was made aware of the findings and no additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to develop and implement a baseline care plan that includes instructions needed to provide and effective person-centered care for 1 Resident (#34) in a survey sample of 60 Residents. The Findings included; For Resident # 34 the facility staff failed to address the Resident's lack of communication as he does not speak English. On 9/12/22 at approximately 2:00 PM an interview was conducted with Resident #34's son. Resident #34's son stated that his father did not speak English. When asked how he communicates with the facility staff he stated, he doesn't. He stated that he has to speak for his father because his father cannot speak English. When asked if they had given the Resident some kind of pictures to show what he needs like food, drink, or toilet. He stated that he has been in the facility every day and has not seen anyone use communication board since his admission on 5/23/22. On 9/14/22 an interview was conducted with CNA F who stated that she knows the Resident doesn't speak English but she goes in and cleans him up and feeds him. When asked how they know what he wants or if he needs a nurse she stated she has not come upon that situation, but if he were in distress or pain she would notify the nurse. On the morning of 9/15/22 an interview was conducted with the DON stated that all departments were represented in the care plan. When asked what should be addressed in the care plan she stated that anything the Resident required to care for him should be in the care plan. When asked if language and communication should be addressed for a Resident who is unable to speak English or unable to speak at all and she stated that it should. When asked for a facility policy on Communication she stated we don't have one, however the Resident Rights Policy read: Page 3 Residents have the right to: vii. Receive proper medical care including but not limited to: 1. To be fully informed about their total health status in a language the resident understands A review of the care plan revealed that communication was not addressed at all. It was not in the care plan that the Resident did not speak English. They did not initiate the use of a communication board until after 9/16/22 when it was addressed to the facility DON. On 9/16/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was made available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40452 Based on observations, staff interview, clinical record review, and facility documentation review, the facility staff failed to develop and/or implement a comprehensive care plan for 3 Residents (Resident #90, Resident #23, Resident #34) in a sample size of 60 Residents. The findings included: 1. For Resident #90, the facility staff failed to include Activities of Daily Living on the comprehensive care plan. On 09/13/2022 at 9:30 A.M., Resident #90 was observed asleep in her bed with the head of the bed elevated approximately 60 degrees. Resident #90 had a plaid clothing protector on with food particles on it. The tray table with the breakfast tray was positioned over the bed and in front of Resident #90. All the food had been eaten off the plate. There was no staff in the room. At 9:36 A.M., Certified Nursing Assistant N (CNA N) entered Resident #90's room, took the tray off the tray table, exited the room, and placed the tray on the cart in the hall. CNA N then re-entered Resident #90's room, walked past Resident #90, and took the roommate's tray to the cart in the hall. CNA N then proceeded to the adjacent room and removed those breakfast trays. At 9:50 A.M., Resident #90 was observed still sleeping with the head of the bed elevated approximately 60 degrees, and the plaid clothing protector on with food particles on it. At 10:00 A.M., CNA N was interviewed. When asked about the process of assisting a Resident after mealtime, CNA N stated that afterwards, she would assist the resident to clean their face, hands, and mouth. When asked why Resident #90 still had a clothing protector on, CNA N stated that she should have taken it off after the meal. When asked why, CNA N stated it's for dignity and make sure she's clean. CNA N then entered Resident #90's room, observed Resident #90 with the clothing protector on, and left the room and headed down the hall stating she was going to get help so Resident #90 could be toileted. CNA N did not remove the clothing protector at that time. On 09/14/2022, Resident #90's clinical record was reviewed. Resident #90's quarterly Minimum Data Set with an Assessment Reference Date of 08/23/2022 coded the functional status for eating as requiring extensive assistance from staff. The Brief Interview for Mental Status was coded as 3 out of 15 indicative of severe cognitive impairment. The care plan was reviewed. There was not a focus, goals, or interventions on the care plan associated with Activities of Daily Living. On 09/13/2022 at approximately 5:30 P.M., the Administrator and Director of Nursing (DON) were notified of findings. When asked about the expectation, the DON stated that if a resident is assisted with eating, the staff should clean up the resident and make sure they are comfortable. The facility staff provided a copy of their policy entitled, Plan of Care Overview. Under the header Policy, an excerpt documented, It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #23, the facility staff failed to address her contracture on the comprehensive care plan. On 09/20/2022 at 2:55 P.M., Resident #23 was observed in her bed. Resident #23 had a contracture of her left upper extremity and there was no positional device observed. At approximately 2:57 P.M., Certified Nursing Assistant Q (CNA Q) was interviewed. When asked about a positional device for Resident #23, CNA Q stated that Resident #23 has one but she hates it and she always throws it away. When asked where the device was located, CNA Q looked around the room and found it in the closet. CNA Q did not attempt to apply the device but put it back in the closet. On 09/20/2022 at 3:02 P.M., the Director of Rehab was interviewed. When asked about the dates of service for therapy for Resident #23, the Director of Rehab referred to Resident #23's clinical record and stated the dates of service were 06/28/22 to 09/15/2022. When asked about therapy recommendations at the conclusion of her therapy care, the Director of Rehab stated that therapy recommended a positional device for her left upper extremity. When asked if Resident #23 tolerates the device, the Director of Rehab stated that She tolerated it really well, some days better than others. At 3:09 P.M., this surveyor and the Director of Rehab entered Resident #23's room to do an observation. The Director of Rehab retrieved the positional device from the closet and positioned it on Resident #23's left upper extremity. Resident #23 tolerated the application of the positional device. At 3:19 P.M., Resident #23 was observed awake in bed still wearing the device. On 09/20/2022, the facility staff provided a copy of Resident #23's Occupational Therapy notes. On the Occupational Therapy Discharge Summary dated 09/15/2022 under the header Patient Response an excerpt documented, Patient tolerating orthotics well. No large gains in ROM [range of motion] however decreased skin to skin contact and risk of skin breakdown and further contracture. Under the header, D/C Recs [discharge recommendations] an excerpt documented, placement of LUE [left upper extremity] orthotics (UE [upper extremity] device and palm protector . On 09/21/2022, Resident #23's clinical record was reviewed. There were no physician's orders for a positional device for Resident #23's left upper extremity. The care plan was reviewed. There was no focus, goals, or interventions pertaining to Resident #23's left upper extremity contracture. On 09/21/2022 at approximately 4:15 P.M., the Administrator and Director of Nursing were notified of findings. When asked about the expectation, the Director of Nursing indicated contracture management should be on the care plan. On 09/22/2022 at 10:45 A.M., the Director of Rehab was interviewed. When asked about the process for therapy recommendations upon discharge from services, the Director of Rehab stated that therapy staff will enter the orders into the electronic health record. When asked why Resident #23 did not have orders for the therapy-recommended orthotic, the Director of Rehab stated, It just got missed. The facility staff provided a copy of their policy entitled, Plan of Care Overview. Under the header Policy, an excerpt documented, It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. 40026 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. For Resident #34 the facility failed to develop and implement a comprehensive person-centered care plan that includes methods of communication for non-English speaking Resident who has also had a stroke. On 9/12/22 during initial tour of the facility an interview was conducted with Resident #34's son. Resident #34's son stated that his father did not speak English. When asked how he communicates with the facility staff he stated, he doesn't. He stated that he has to speak for his father because his father cannot speak English. When asked if they had given the Resident some kind of pictures to show what he needs like food, drink, or toilet. He stated that he has been in the facility every day and has not seen anyone use communication board since his admission on 5/23/22. On 9/14/22 an interview was conducted with CNA F who stated that she knows the Resident doesn't speak English but she goes in and cleans him up and feeds him. When asked how they know what he wants or if he needs a nurse she stated she has not come upon that situation, but if he were in distress or pain she would notify the nurse. On 9/14/22 at approximately 2:30 PM an interview was conducted with LPN D who stated that if she had a patient that could not speak English, she would use translator phone number. When asked how she would know what language the Resident spoke she said it's in the admission paperwork and it should be in is care plan. A review of the comprehensive care plan revealed that the Communication needs of Resident #34 were not addressed in the comprehensive care plan. On 9/14/22 a review of the clinical record was conducted the following are excerpts from the record: A review of the Admission Assessment page 2 read: 2. Cognitive Status / Orientation 1. Able to report correct year (box checked) x Not assessed 2. Able to report correct month (box checked) x Not assessed 3. Able to report correct day of the week (box checked) x Not assessed 4. Verbalizes or demonstrates use of (select all that apply) (Box checked) x Call bell/light 5. Is English primary language? (Box checked) x NO 6. Primary language (No box checked area left blank) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was made available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40452 Based on observation, family interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to revise the care plan for 7 Resident (Resident #318, Resident #78, Resident #68, Resident #318, Resident #86, Resident #35, Resident #14) in a sample size of 60 Residents. The findings included: 1. For Resident #318, the facility staff failed to address communication on the care plan. On 09/12/2022 at 3:50 P.M., Resident #318 was observed awake in her bed. When asked if she had any concerns about the care received at the facility, Resident #318 spoke in a foreign language. There were no communication aids or language line number observed at the bedside. On 09/13/2022, Resident #318's clinical record was reviewed. Under the Assessment tab in the electronic health record, there was no evidence Resident #78's understanding of the English language was assessed. According to the Face Sheet under the section Primary Language, it was documented, Hindi. According to the Admission Evaluation dated 08/31/2022 under Section 5 entitled, Is English primary language? the answer no was selected. In Section 5a entitled, Primary Language it was documented, Paru. Under the Miscellaneous tab in the electronic health record, there was a scan entitled, Admission info. A document form another facility entitled, Admission Record Report documented that Resident #318's primary language was Farsi. Resident #318's care plan did not have a focus, goals, or interventions addressing Resident #318's primary language and communication management to effectively communicate with Resident #318. On 09/19/2022, the facility staff provided a copy of their policy entitled, Plan of Care Overview. Under the header Policy, it was documented, It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. The purpose of the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to the their daily routines and goals to potentially return to a community setting. On 09/21/2022 at 9:55 A.M., Resident #318 was observed with a visitor at the bedside. The visitor indicated she was a family friend and visits often in the morning-time. When asked about Resident #318's primary language, the family friend stated Urdu. When asked about Resident #318's ability to understand/communicate in English, the family friend stated that Resident #318 understands some English, but not everything. The family friend also stated that Resident #318 can speak a few words in English. When asked how the staff communicated with Resident #318, the family friend stated she didn't know because they're not here when I'm here. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/21/2022 at approximately 10:00 A.M., Certified Nursing Assistant W (CNA W) was interviewed. CNA W verified she was assigned to care for Resident #318. When asked for Resident #318's primary language, CNA W indicated she didn't know. CNA W then stated that Resident #318 sometimes speak English but she is not fluent. On 09/21/2022 at approximately 10:05 A.M., Registered Nurse D (RN D) was interviewed. RN D verified she was assigned to care for Resident #318 this day. When asked for Resident #318's primary language, RN D stated that she didn't know and added that she doesn't speak much English. When asked how she communicates with Resident #318, RN D stated that she understands when we talk with her. RN D also stated that the family friend that visits in the morning will help as well. The facility staff provided a copy of their policy entitled, Plan of Care Overview. Under the header Policy, an excerpt documented, It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. On 09/21/2022 at approximately 4:15 P.M., the Administrator and Director of Nursing were notified of findings. 2. For Resident # 78, the facility staff failed to address communication on the care plan. On 09/12/2022 at 12:45 P.M., Resident #78 was observed in bed awake. When I asked if she had any concerns about the care received at the facility, Resident #78 motioned to their neck and pointed to her roommate, Resident #38. Roommate (Resident #38) stated that [Resident #78] cannot speak but responds to yes/no questions. The Roommate (Resident #38) also stated that [Resident #78]'s primary language is not English. This surveyor observed there were no communication aids in the room and no information about a language line was observed. The roommate (Resident #38) was asked if staff used interpreter to communicate with Resident #78, and the roommate stated staff sometimes ask her to interpret because she can also speak Resident #78's primary language. When asked what she is asked to interpret, the roommate Resident #38 stated, I let them know what food she doesn't like or I let them know when she has an upset stomach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/13/2022, Resident #78 clinical record was reviewed. Under the Assessment tab in the electronic health record, there was no evidence Resident #78's understanding of the English language was assessed. According to the Face Sheet under the section Primary Language, it was documented, English. According to the Admission Evaluation dated 09/13/2017 under the section entitled, Communication, the choices were English or Other. The option Other was selected and Spanish was written in the text box. A focus on the care plan initiated on 09/20/2017 entitled, [Resident #78] has a communication problem r/t Expressive Aphasia, Language barrier, Anarthria and dysarthria documented the following interventions: Anticipate and meet needs. Be conscious of resident position when in groups, activities, dining room to promote proper communication with others. Ensure/provide a safe environment: Call light in reach, adequate low glare light, Bed in lowest position and wheels locked, Avoid isolation. Another focus on the care plan was entitled, [Resident #78] is a native (Chilies, Mexican, etc.) and English is the her [sic] second language. The language barrier may limit participation during programs. Interventions associated with this focus were the following: Assess previous and current leisure interests and lifelong routines. [Resident #78] enjoys attending religious services and will be added to church list .Invite, remind and encourage to activities of stated interests as requested and tolerated. Offer and support according to needs and preferences: (life review activities, quality time with chosen relatives, friends, staff, other residents, spiritual support, touch, massage, music of preference, reading aloud, reading of preference, etc.). Offer social, recreational and volunteer visits within her tolerance and preferences. Provide and review monthly calendar with resident, offer alternatives that can be done individually. Provide one-on-one visits (in the room, at bedside, etc.) to stimulate senses and provide contact, target supportive programs such as (listening to relaxing music, hand massage, relaxation techniques). Respect her right to refuse groups and set own leisure routine. Staff will invite, remind and escort to programs of interests. Another focus on the care plan dated 04/25/2022 entitled, [Resident #78] has a communication problem r/t [related to] other disease process / condition had the following interventions: Observe effectiveness of communication strategies and assistive devices. Observe for declines in communication. Observe/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed. There were no interventions on the care plan addressing how to effectively communicate with Resident #78. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/14/2022 at 9:30 A.M., this surveyor observed Licensed Practical Nurse H (LPN H) administer medications to Resident #78. As this surveyor and LPN H entered the room, Resident #78 grimaced, held up 2 fingers, then pointed to her abdomen. As LPN H offered the Colace (a laxative), Resident #78 motioned with her hand and shook her head no. LPN H spoke to Resident #78 in English and asked Resident #78 if she was having loose stools and Resident #78 nodded her head yes and held up 2 fingers. LPN H asked Resident #78 if she had 2 loose stools and Resident #78 nodded her head yes. LPN H returned to the medication cart after the med pass and stated to this surveyor that Resident #78 had anti-diarrhea available to administer as needed. When asked how staff communicate with Resident #78, LPN H stated that staff don't use an interpreter because [Resident #78] cannot speak and she understands English. LPN H then approached Certified Nursing Assistant H (CNA H) and asked if Resident #78 had loose stools this day. CNA H stated that Resident #78 has not had a bowel movement this day. When asked how staff communicate with Resident #78, CNA H stated, We've been around her a long time; we just know what she is saying. LPN H then saw the nurse practitioner (Employee FF) in the hall and informed her of the loose stools. The nurse practitioner then started walking toward Resident #78's room. This surveyor asked to observe the nurse practitioner interact with Resident #78. The nurse practitioner stated, Do you have to be there? I'll be asking [Resident #78] a lot of questions. The nurse practitioner then turned to the nurse (LPN H) and stated she would need an interpreter. LPN H walked down to the nurse's station to ask the unit manager about an interpreter. LPN H returned and stated that the unit manager, Registered Nurse C (RN C), went to the basement to get an interpreter. On 09/14/2022 at 10:15 A.M., the Assistant Director of Nursing, RN E, was interviewed. When asked how staff communicate with Resident #78, the Assistant Director of Nursing (ADON) indicated she didn't know and stated Let me get that information for you. The ADON then stated that she would go to an interpretation site on the internet. At approximately 10:18 A.M., CNA O was asked how staff communicate with Resident #78 and CNA O stated that there are two housekeepers that speak the same language as Resident #78. The staff were identified and placed in staff identifier as Employee Q, a laundry aide and Employee R, a housekeeper. On 09/14/2022 at 10:21 A.M., LPN H provided a document entitled, Language Line with a phone number and PIN. On 09/14/2022 at 10:30 A.M., the ADON provided a copy of another document entitled, Language Line with a different phone number and PIN. The ADON stated that this was the correct one because she got it from the social worker. On 09/15/2022 at 9:20 A.M., Employee Q was interviewed. When asked if the staff ask her to interpret for Residents, Employee Q stated that sometimes she would interpret but I only speak a little bit of English. When asked how often she serves as interpreter, Employee Q indicated she didn't understand the question and wanted to get her supervisor to interpret the question. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/15/2022 at 9:30 A.M., Employee R was interviewed. When asked if staff ask her to interpret, Employee R stated that the nurses ask her to interpret. Employee R also stated that she is not fluent in English but understands a little bit. When asked which Residents she serves as interpreter, Employee R stated Resident #78's name and Resident #6 in the sample. Employee R stated that sometimes Resident #6 will say she has pain in her leg or hip. Employee R stated Resident #6 speaks no English. When asked about Resident #78, Employee R stated that when she is interpreting for Resident #78, sometimes she will need medication. Employee R stated that Resident #78 Doesn't talk, only answers yes/no questions. I will ask her questions and she will answer. Employee R stated that she interprets when the doctor is seeing her and sometimes the nurses will ask me to go in there and check on her. On 09/15/2022 at approximately 6:45 P.M., the Administrator and Director of Nursing were notified of findings. The facility staff provided a copy of their policy entitled, Plan of Care Overview. Under the header Policy, an excerpt documented, It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. 3. For Resident #34 the facility failed to develop and implement a comprehensive person-centered care plan that includes methods of communication for a non-English speaking Resident who has also had a stroke. On 09/12/2022 at approximately 12:35 P.M., Resident #68 was interviewed. When asked about having any concerns about care at the facility, Resident #68 stated that he has not received physical therapy. On 09/13/2022, Resident #68's clinical record was reviewed. A physician's order dated 08/10/2021 documented, Physical therapy evaluate and treat for generalized weakness, bilateral lower extremity weakness. Resident #68's care plan was reviewed. A focus initiated on 12/23/2019 entitled, [Resident #68] has hemiplegia/hemiparesis to left side r/t [related to] stroke. The goal associated with this focus initiated on 12/23/2019 and revised on 12/06/2021 documented, [Resident #68] will maintain optimal status and quality of life within limitations imposed by hemiplegia/hemiparesis through review date. An intervention associated with this focus initiated on 12/23/2019 included but was not limited to PT, OT, ST evaluate and treat as ordered. There was no evidence the care plan was reviewed quarterly or revised when the physician ordered physical therapy services on 08/10/2021. On 9/15/22 at 9:50 AM, Employee E was asked about care planning. She said, The care plan is reviewed every 90 days. When asked when a change occurs, when that would be reflected in the care plan, Employee E said, The care plan should get updated that same day as to when the change occurred. The facility staff provided a copy of their policy entitled, Plan of Care Overview. Under the header Policy, an excerpt documented, It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. 31199 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. For Resident #318, the facility staff failed to revise the comprehensive care plan to include interventions for newly aquired pressure sores. The findings included: Resident #318, an [AGE] year old, was admitted to the facility on [DATE]. Diagnoses included hypertension, dementia, adult failure to thrive, deprssion, and an open left buttocks pressure wound. Resident #318's most recent Minimum Data Set assessment was not yet submitted.on 9-12-22. The Resident required total dependance on staff for all activities of daily living. On 9-5-22 physician's orders were received for treatments to newly aquired deep tissue injury to bilateral heels, and a stage 2 sacral wound. There was no progress note in the clinical record for a visit on this date. The first progress note of any kind found in the clinical record was a physician visit on 9-9-22. Resident #318 was seen by the physician on 9-9-22 who documented in a progress note recommendations for newly developed pressure wounds on the sacrum, and both heels in the note. Those recommendations included the following; 1. Air matress 2. Emollients to feet 3. Nutrician consult 4. Heel protection Resident #318's care plan was reviewed and revealed none of the ordered treatments from 9-5-22, nor new physician recommendations from 9-9-22 were placed on the care plan to guide treatment. At the end of day meeting on 9-15-22, the Administrator, and DON were notified of the concerns regarding the lack of implementing revisions to careplans to address the management of pressure sores. They were asked if it was the facility's policy to review and revise care plans with treatment plans for wounds, and both agreed it was their policy to do so. No further information was provided by the facility. 40026 5. For Resident #86 the facility staff failed to review and revise the care plan as the tube feeding and oral feeding orders changed. On 9/12/22 at approximately 4:00 PM the following observation was made: Tube feed Jevity 1.2 was hanging and infusing via enteral pump at 45 ml per hour. The 60 ml piston syringe was not dated and the tube feeding was not dated nor was the tubing. On 9/12/22 at end of day meeting the DON was asked for the tube feeding policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/13/22 at approximately 2PM the tube feeding policy was again requested. On 9/13/22 a review of the clinical record revealed that Resident # 86 was admitted on [DATE] with diagnoses that included dysphasia, failure to thrive, and a peg tube had been inserted. Resident #86's signed admission orders for diet read: NPO (Nothing by Mouth), NPO Texture, NPO Consistency dated 8/13/22 The physician put in enteral Feed orders that read: Enteral Feed Order As needed flush. Flush with at least 30 ml. [Resident name redacted] requires, tube feeding Date Initiated: 08/13/2022 Revision on: 08/13/2022 (Please note that no Tube Feeding was ordered only flushes were ordered) The baseline care plan read: FOCUS [Resident #86 name redacted] will maintain adequate nutrition and hydration status though review date. Date Initiated: 08/13/2022 Revision on: 08/13/2022 GOAL [Resident #86 name redacted] will remain free of complications through review date Date Initiated: 08/13/2022 Revision on: 08/13/2022 INTERVENTION: Administer flushes per medical provider's order. Date Initiated: 08/13/2022 Administer medications via tube, per orders. Date Initiated: 08/13/2022 Check for placement and residuals per policy. Date Initiated: 08/13/2022 Head of bed elevated 30 degrees or higher. Date Initiated: 08/13/2022 Nutritional consult on admission, quarterly, and PRN. Date Initiated: 08/13/2022 Obtain weights as ordered. Date Initiated: 08/13/2022 Provide supplemental meals per diet order. Provide assistance with meals as needed. Date Initiated: 08/13/20 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**Please note it says Nutritional Consult on Admission and PRN. No consult was done until 8/25/22 (2 weeks after admission) ** On 9/19/22 at approximately 4PM an interview was conducted with the DON who was asked how the care plan is developed. She stated the Interdisciplinary team meets and we each have a part of the care plan. Who is on the interdisciplinary team she stated a member from each department the doctor, nursing, food services, therapy and social work and activity as well as the Resident or family member. A review of the care plan policy revealed that When asked about Resident #86's interdisciplinary team with regards to her tube feeding, how much where were the orders and how was she eating. The DON stated she gets tube feeding and when asked about the tube feeding she could not answer why no tube feeding only flushes had been ordered from 8/13/22-8/25/22. She did not know why it took so long to get a Nutrition consult for the Resident. When asked w Another request for the tube feeding policy and procedure was made at that time. Surveyor: [NAME], Crystal 6. For Resident #14, who developed a contracture of her left elbow, wrist and hand while a Resident of the facility, the facility staff failed to review and revise the care plan to identify the contracture and limited range of motion. On 09/12/22 at 02:49 PM, Resident #14 was visited in her room and a family member was at the bedside. A Resident and family interview were conducted. Resident #14's family member said he is very concerned about the Resident's left hand, she is no longer able to use it and when you touch it she has pain. The family member confirmed that Resident #14's hand was not like this when she came to the facility. During the above interview, Surveyor B observed Resident #14's left hand and noted that her fingers appeared to be contracted in a closed position, her wrist appeared to have some limited movement as well. When asked if she (Resident #14) could open her hand she was not able to do so independently. Review of the clinical record for Resident #14 revealed the following entries that noted the contracture(s): a. A physician order dated 7/13/22, that read, OT [occupational therapy] evaluation for splint for left hand contracture of fingers. A progress note written by the provider the same day read, .Assessment / Plan 1. Contracture of multiple joints- particularly left hand with apparent pain with movement and when try to examine it but seems comfortable when left alone . b. A physician progress note dated 8/23/22, that read, .Follow-up: Contracture of multiple joints . Musculoskeletal System: Hand: no erythema or warmth and limited both active and passive extension left finger(s); able to move arm to examine and hand but does draw away when attempt to open fingers, rings on fingers but distal neurovascular intact. Musculoskeletal System contracture of extremities . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. The MDS [minimum data set/an assessment tool] conducted 3/6/22, which was coded as an annual assessment was reviewed. This assessment was coded in section G0400. Functional Limitation in Range of Motion, question G0400 A: Upper extremity (shoulder, elbow, wrist, hand): no impairment d. The MDS [minimum data set/an assessment tool] conducted 6/24/22, which was coded as a quarterly assessment was reviewed. This assessment was coded in section G0400. Functional Limitation in Range of Motion, question G0400 A: Upper extremity (shoulder, elbow, wrist, hand): no impairment On 9/15/22 at 7:20 PM, the therapy director provided the survey team with a copy of the Occupational Therapy (OT) evaluation that was completed for Resident #14 on 9/15/22. It read, .Reason for Referral: Patient is a 88 y/o [year old] female referred to skilled OT evaluation for assessment and management of LUE [left upper extremity] flexor contractures at elbow, wrist and hand due to hx [history] of R [right] intracranial hemorrhage LUE [left upper extremity] ROM [range of motion]= Impaired (L wrist rests in 80 degrees flexion with ~30 degrees of passive extension from fixed position available. L D3 [left digit 3/finger] and 4 most severe with 90 degree contractures from MCP [Metacarpophalangeal joint/commonly known as knuckles] to DIP [Distal Interphalangeal Joint/bones at the tip of the fingers]. L thumb proximal phalange in fixed adducted position with hyperextension of IP joint, unable to form functional grasp. L D2 and D5 [left digit 2 and 5/ index and pinky fingers] are least affected with resting MCP flexion at 90 degrees and ability to extend 45 degrees from this position, distal segments flaccid and passively WFL [Within Functional Limits]. L elbow passively WFL, shoulder flexion PROM [passive range of motion] 0-120 degrees and AROM [active range of motion] 0-35 degrees; patient rests in elbow flexion (~70 degrees) and internal rotation . The evaluation by OT revealed Resident #14 had significant impairments/limitations of her left arm and hand due to the contractures. Resident #14's care plan was reviewed and did not identify or address the hand contracture and therefore no interventions were in place to prevent further decline. On 9/15/22 at 9:50 AM, an interview was conducted with Employee E, the social worker, who confirmed she is a member of the interdisciplinary care plan team. Employee E was asked about care planning during the above interview. She said, The care plan is reviewed every 90 days. When asked when a change occurs, when that would be reflected in the care plan, Employee E said, The care plan should get updated that same day as to when the change occurred. Review of the facility policy titled, Plan of Care Overview was conducted. The policy read, PoC [plan of care]: for the purpose of this policy the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care .1. d. The facility will: iii. Review care plans quarterly and/or with significant changes in care . On 9/21/22, the facility Administrator and Director of Nursing were made aware of the above findings during an end of day meeting. No additional information was received. 7. For Resident #35, the facility staff failed to review and revise the care plan to reflect a change in discharge plan when it was determined the Resident would remain in the facility for long-term care versus returning home. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/12/22 at 3:07 PM, Resident #35 was interviewed. During the interview, Resident #35 said, I would rather go home and do the best we can versus stay here and go broke. A clinical record review for Resident #35 revealed a care plan that read, [Resident #35's name redacted] wished to be discharged to home when his skilled therapy service end. Also in the clinical record there was evidence that skilled care ended and his payer status/source changed on 7/13/22. A progress note dated 5/12/22, read, .planning to stay in LTC [long-term care] facility . On 9/15/22 at 9:50 AM, an interview was conducted with Employee E, the social worker. Employee E stated, The goal was to transition him [Resident #35] home, he needs supervision. He looked at an assisted living facility and the decision to leave changed. Employee E said she worked with Resident #35 and his spouse about a month and a half ago to transfer to an assisted living. Employee E was asked about care planning during the above interview. She said, The care plan is reviewed every 90 days. When asked when a change occurs, when that would be reflected in the care plan, Employee E said, The care plan should get updated that same day as to when the change occurred. Review of the facility policy titled, Plan of Care Overview was conducted. The policy read, PoC [plan of care]: for the purpose of this policy the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care .1. d. The facility will: iii. Review care plans quarterly and/or with significant changes in care . On 9/21/22, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above concern of Resident #35's care plan still indicating a goal to return home. No further information was provided. 41449

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure services were provided that meet professional standards of care for 3 Residents (#'s 217, 88, and 417) in a survey sample of 60 Residents, resulting in harm for Resident #217. The findings included: 1. For Resident #217, the facility staff failed to assess, monitor and treat for Diabetes resulting in Harm. Documentation in the hospital records on Admission to the facility showed orders for a Carbohydrate Controlled Diet and Glucerna Shake. Both of these were indications that Resident # 217 might have been a Diabetic. Resident #217 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Asthma, Congestive Heart Failure (CHF), Chronic Kidney Disease Stage 3, Hypertension, Atrial Fibrillation, Obstructive Sleep Apnea (OSA), Infection due to Multi-resistant organism and Morbid Obesity with BMI (Body Mass Index) ,d+[DATE]. The MDS coded Resident #217 as requiring extensive to total assistance of one to two staff persons with activities of daily living and frequently incontinent of bowel and bladder. Review of the electronic clinical record revealed there was no documentation of a diagnosis of Diabetes listed in the record. There was no documentation of an order for the medication, Metformin. Review of the listed diagnoses did include Hypertension (high blood pressure) and Kidney failure. The Admission face sheet stated short term and D/C (discharge) back home with daughter. Review of the Progress Notes revealed a note written by the Nurse Practitioner on [DATE] at 16:22 (4:22 p.m.) which stated Resident # 217 was seen for complaints of increased edema and blisters. The resident was noted to have wheezing on examination by the Nurse Practitioner. The note included the following excerpt Noted to be having wheezing, SOB and increased work of breathing. Sat 87% on room air with abdominal breathing. The note also included the following Assessment and Plan: Acute Respiratory Failure with Hypoxia, Placed on 5 liters of Oxygen , nebulizers were given , placed on CPAP temporarily. if not improvement in dyspnea may need ER evaluation On [DATE] at 16:50 (4:50 p.m.), nurse documented Resident # 217 was alert and oriented x 3, had 3 + (3 plus) edema on bilateral lower legs, blisters, redness, warmth to the right lower leg, DTI to the sacrum, and redness and rash to the peri area. Wound nurse notified, Nurse Practitioner notified, son notified. Interview conducted on [DATE] with the Director of Nursing who stated she did not see a diagnosis of Diabetes for Resident # 217 in the clinical record. The Director of Nursing stated the facility staff normally would review the hospital records upon admission to the facility. Any diagnoses would be carried over to the Admission Notes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Responsible Party via telephone on [DATE] at 9:31 a.m. Resident # 217's son stated the resident had been a known Type 2 Diabetic for over [AGE] years and had been taking Metformin. He stated the resident was aware of the diagnosis and that she told the staff that she was a Type 2 Diabetic. He stated medications were given by staff who did not explain what each pill was being taken for. Review of the Hospital Discharge Records dated [DATE] for admission to the facility revealed no diagnosis of Diabetes in the list of diagnoses. Further review of the documents revealed documentation of an order for a Carbohydrate Controlled Diet and Glucerna. According to the American Diabetes Association, the Carbohydrate Controlled Diet Helps people with diabetes keep their carbohydrate consumption at a steady level, through every meal and snack. On [DATE] at 11:15 a.m., an interview was conducted with the Director of Nursing regarding Admission History and Physicals. The Director of Nursing stated the doctors come on Mondays and Fridays to review new admissions, review the history and physical, do the initial History and Physical on Admission usually on Mondays or Tuesdays. The Director of Nursing stated the Nurse Practitioners are in the facility Monday through Friday. She stated that there are two Nurse Practitioners who come to the facility and one just started recently. An interview was conducted with the Medical Director via telephone on [DATE] at 6:28 PM. An interview was conducted over the phone with the call on speaker phone with all 6 surveyors present. The Medical Director stated he was aware that the facility was being surveyed during the past week and that the surveyors were back to complete the survey. The Medical Director stated he had been out of town at a meeting in Richmond and was going out of town for the next 10 days. The Medical Director was asked about the process for obtaining history and physical information on new admissions to the facility. The Medical Director stated one of the three physicians who see residents in the facility. The Medical Director stated the facility accepts the patients. We (doctors) don't decide who gets admitted . The facility knows what they can do. The Administrative team makes the decision about who gets admitted . When asked about the process of determining chronic disease diagnoses, the Medical Director stated we look at the records from the hospital. The hospital has their history. It's their responsibility to obtain an accurate history. We have the patient for Physical Therapy. We have them for a short time. If there are signs and symptoms, we would check labs. Then the Medical Director questioned the surveyor Why don't you ask the Hospital why they didn't do it? They are supposed to do a medical history. We review that history. It is not standard of practice to check A1C on residents or check for Diabetes unless they have a history or have medicine for Diabetes. We review the hospital records, examine the patient and look at the medicines. I've worked in the hospital before. The hospital is supposed to check the medical history. They do lab work there routinely. We don't routinely do labs for rehab patients unless they have signs and symptoms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	When asked if a Blood Glucose result of 145 was considered an indication of a need for further follow up, The Medical Director stated it depends on whether the resident was fasting or nor. An A1C (Hemoglobin A1C) is not indicated unless there are signs or symptoms of Diabetes. The Medical Director was asked if a resident 5 foot 3 inches tall weighing over 370 pounds was a person that might need close follow up to determine if there was Diabetes. The Medical Director again stated that the facility would check the hospital records to see if there was a previous diagnosis of Diabetes. The Medical Director was asked about Residents with Diabetes who were managed by Diet alone or what if the hospital did not obtain a complete medical history. The Medical Director again stated the hospital was supposed to obtain the medical history and the facility would review those documents to obtain the information. The Medical Director was asked if the facility staff ever contacted the Primary Care Physician to make sure an accurate history was obtained. The Medical Director stated no. When the Medical Director was informed that Resident # 217 had a Blood Sugar of 844 that was obtained at the facility but not resulted out until after the transfer to the hospital., the Medical Director stated that could have been an acute thing. It could have just happened. She had no signs or symptoms. The Medical Director was asked if he thought there was a potential for important diagnoses to be missed if the facility staff was relying on the discharging hospital to provide all of the history and physical information. The Medical Director stated the hospital was supposed to be obtain a complete history and physical and the facility would review that information when the resident was admitted to the facility. He then stated the nursing staff would ask information during the admission assessment but would use the hospital discharge summary. The physician at the facility would examine the resident and interview them about the medical history. On [DATE] at 10:45 a.m., another surveyor interviewed one of the physicians (Employee T) about another resident in the survey sample. Employee T was listed on the hospital discharge Summary (and in the clinical record) as the Primary Care Provider for Resident #217. This surveyor immediately asked the Regional Nurse Consultant to have Employee T to call this surveyor. The Regional Nurse Consultant stated Employee T had already left the facility but a message had been left for her to call the surveyor. The Regional Nurse Consultant stated she spoke with Employee T and that Employee T checked her records mentioned something about Diabetes and noted that Resident # 217 had not been her patient anymore for 3 years but may have been seen by one of the partners in the group. Requests were made to have the physician (employee T) to call this surveyor. The Regional Nurse Consultant stated the physician wanted to make sure the family gave permission for her to talk with the surveyors due to HIPPA. This surveyor informed the Regional Nurse Consultant that the Resident's son was aware and told the surveyor to call the Primary Care Doctor to gather information. Employee T never returned the call to the surveyor. Several attempts to reach the physician (Employee T) were unsuccessful while on survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:45 a.m., an interview was conducted with the Regional Nurse Consultant who stated she reviewed the clinical record and could not find any documentation that Resident # 217 had Diabetes. She stated she did find evidence of an order for a Diabetic Diet and Glucerna on the hospital discharge records in [DATE] that were used for admission to the facility. The Regional Consultant stated that when the labs were ordered and results came back, Resident # 217 was already in the hospital. The Regional Consultant stated we probably should have been checking the blood sugar due to the Diet Order and the Glucerna which are both used for Diabetes. That was a clue She also stated the facility staff should do a thorough History and Physical to include interviewing the resident, family members and the Primary Care physicians. The family should be asked about past medical history too. Review of the Blood Sugar readings revealed documentation of two elevated Comprehensive Metabolic Profile blood sugar results in [DATE]. There were no other Blood Glucose results noted that were drawn after the level of 145 in [DATE] in the clinical record. According to the lab report, normal range is less than 110. There was no noted follow up to check the Hemoglobin A1C after the documented elevated blood glucose level. [DATE]- CMP-glucose =118 [DATE]-CMP-glucose =145 [DATE]-CMP-glucose =844 There was no documentation of a Hemoglobin A1C being ordered for Resident # 217. The A1C evaluates the amount of glucose in the blood over the last two to three months. Resident # 217 had several risk factors that would indicate a work up or evaluation for Diabetes including age, race, BMI greater than 60 and elevated blood glucose levels on routine lab work while in the facility. Resident # 217 was alert and oriented. According to Resident # 217's son, Resident #217 stated 'that;s a lie, I told them. There was no documentation that the facility staff asked questions about a previous history of Diabetes. The was no was documentation that anyone assessed the clinical picture of told about the diagnosis Based on review of the clinical record, interviews, and facility documentation review, the facility staff failed to assess, monitor and treat Resident # 217. Documentation in the hospital records on Admission to the facility showed orders for a Carbohydrate Controlled Diet and Glucerna Shake. Both of these were indications that Resident # 217 might have been a Diabetic. When Resident # 217 was transferred to the hospital on [DATE], the Blood Sugar was 844. Resident # 217 was immediately taken to the Intensive Care Unit and stayed for a few days. Upon discharge from the hospital, Resident # 217 went to another facility because she refused to return to the facility. He stated Resident # 217 had to have a partial amputation while in the hospital. The numbers were not right. So, they could not do the entire amputation. He stated Resident # 217 had to be hospitalized again and had pneumonia, COVID and 'Kidney Failure. The resident expired in [DATE]. Resident # 217's son stated that during the pandemic, we could not advocate for her. We could not see her. We had to trust what the facility was telling us. That started a lot of the problems. We could not see what was happening. We did not get answers from the staff when we called to express our concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	During the end of day debriefings on [DATE] and [DATE], the facility Administrator, Director of Nursing and Regional/Corporate Consultants were informed of the findings. No further information was provided. COMPLAINT DEFICIENCY at a HARM level 40026 2. For Resident #88 the facility staff failed to check the physicians order against the medication to ensure the proper dose of medication. On [DATE] at approximately 2:00 PM an interview was conducted with Resident # 88 who stated that he has been getting the wrong dose of medication for his blood clots and just found out this week it was the wrong dose. He stated his doctor that he sees for his blood clot had put him on shots in the stomach and the medication should have been 100 mg every 12 hrs. but that he was only getting 80 mg. A review of the clinical record revealed that Resident #88 had physician's orders that read: [DATE] 8:15 PM Enoxaparin Sodium Injection Solution Prefilled Syringe 100 MG/ML (Enoxaparin Sodium) Inject 1 ml subcutaneously every morning and at bedtime for clotting . [DATE] at 21:00 Medication: Enoxaparin Sodium Injection Solution Prefilled Syringe 80 MG/0.8M Generic: Enoxaparin Sodium Medication Class: ANTICOAGULANTS . Enoxaparin Sodium Injection Solution Prefilled Syringe 80 MG/0.8ML (Enoxaparin Sodium) Inject 100 mg/ml subcutaneously every 12 hours for PE/DVT until [DATE] 12:02 for 8 administrations. (**Please note the prefilled syringe was ordered at 80 mg/ 0.8 ml not the 100 mg/ml that was ordered) A review of the MAR (Medication Administration Record) for the month of [DATE] revealed the record was signed off as being given as follows: Enoxaparin Sodium Injection Solution Prefilled Syringe 100 MG/ML (Enoxaparin Sodium) Inject 1 ml subcutaneously every morning and at bedtime for clotting -D/C Date[DATE] Time:14:13 Please note the Resident received the correct dose for [DATE] and [DATE] the order was then discontinued and the following (incorrect) order was initiated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	Enoxaparin Sodium Injection Solution Prefilled Syringe 80 MG/0. 8ML (Enoxaparin Sodium) Inject 100 mg/ml subcutaneously every 12 hours for PE/DVT until [DATE] 12:02 for 8 administrations On [DATE] at 9:30 AM an interview was conducted with LPN C who was asked how she administers Lovenox injections and she stated that she looks at the order and the medication available in the drawer making sure the order and the medication are the same before administering the medication. On [DATE] at approximately 3:00 PM an interview was conducted with the DON who was asked if the nurses should be checking the dosage with the medication and comparing to ensure proper dosage. She stated that this is the expectation for all nurses to perform he Rights of medication administration. When she was asked about the Lovenox order for Resident #88 she stated was aware that this happened but she insisted that the Resident was never given in the wrong dose. She stated that the medication was ordered and received by the pharmacy in the 100 mg / 1 ml prefilled syringes. When asked why the order was changed from the original (correct) ordered dosage to an incorrect dose she stated that the nurse who put the order in the system hit the wrong line on the drop down box and ordered 80 mg/0.8 ml instead of the 100 ml / ml, When asked if anyone clarified the order to see what the correct order should be when comparing the dose ordered with the medication on hand she stated they did not. Guidance for nursing standards for the administration of medication is provided by Fundamentals of Nursing, 7th Edition, Mosby's/ Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing Scope and Standards of Nursing Practice of (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation. On [DATE] during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 41450 3. For Resident #417, the facility staff failed to administer 5 medications, Trazadone, Clonazepam, Galantamine Hydorbromide, Lamotrigine, and Pantoprazole as ordered by the physician on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	On [DATE], in the course of a complaint investigation, the clinical record for Resident #417 was reviewed in its entirety, with particular attention given to physician orders and medication administration. Resident #417 was admitted to the facility on [DATE] at 12:30 PM. The clinical record revealed: A physician's order was placed on [DATE] for Trazadone HCl Tablet 50mg .give 1 tablet by mouth at bedtime for Insomnia. The Medication Administration Record (MAR) indicated the Trazadone was scheduled to be given at 08:00 PM beginning on [DATE], however a chart code, 9=Other/See Progress Notes was documented. The corresponding progress note read, Awaiting pharmacy arrival. Resident #417 did not receive the medication until the next scheduled dose, the following day, on [DATE] at 08:00 PM which constituted 1 missed dose. A physician's order was placed on [DATE] for Clonazepam Tablet 0.5mg .give 0.5 tablet by mouth two times a day for Anxiety. The MAR indicated the Clonazepam was scheduled to be given at 09:00 PM beginning on [DATE], however a chart code, 9=Other/See Progress Notes was documented. The corresponding progress note read, Awaiting pharmacy arrival. Resident #417 did not receive the medication until the next scheduled dose, the following day, on [DATE] at 09:00 AM which constituted 1 missed dose. A physician's order was placed on [DATE] for Galantamine Hydrobromide Tablet 4 mg .give 1 tablet by mouth two times a day for Dementia. The MAR indicated the Galantamine was scheduled to be given at 09:00 PM beginning on [DATE], however a chart code, 9=Other/See Progress Notes was documented. The corresponding progress note read, Awaiting pharmacy arrival. Resident #417 did not receive the medication until the next scheduled dose, the following day, on [DATE] at 09:00 AM which constituted 1 missed dose. A physician's order was placed on [DATE] for Lamotrigine Tablet 150mg .give 1 tablet by mouth two times a day for Mood Disorder. The MAR indicated the Lamotrigine was scheduled to be given at 09:00 PM beginning on [DATE], however a chart code, 9=Other/See Progress Notes was documented. The corresponding progress note read, Awaiting pharmacy arrival. Resident #417 did not receive the medication until the next scheduled dose, the following day, on [DATE] at 09:00 AM which constituted 1 missed dose. A physician's order was placed on [DATE] for Pantoprazole Sodium Tablet Delayed Release 20mg .give 1 tablet by mouth two times a day for GERD [Gastroesophageal Reflux Disease] before meals. The MAR indicated the Pantoprazole was scheduled to be given at 04:30 PM beginning on [DATE], however a chart code, 9=Other/See Progress Notes was documented. The corresponding progress note read, Awaiting pharmacy arrival. Resident #417 did not receive the medication until the following day, [DATE], at 04:30 PM, which constituted 2 missed doses. There was no documentation in the clinical record that the physician was notified that the ordered medications were awaiting pharmacy arrival and not given as ordered. On [DATE], an interview was conducted with the Corporate Clinical Nurse who stated, If meds are not available from pharmacy, I expect the nurse to call the ordering doctor, that would give the doctor options to change the medication orders if needed .I would expect to see a note in the clinical record that the nurse notified the doctor of the situation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	The Facility Administrator and Director of Nursing (DON) were updated on the findings. The DON stated that the facility's professional nursing standard reference was Lippincott. A facility policy on medication administration was requested and received. Review of the facility policy entitled, Medication Administration, review date [DATE], heading, Procedure read, I. General Procedures: a. Administer medication only as prescribed by the provider and f. Observe the 'five rights' in giving each medication: the right resident, the right time, the right medicine, the right dose, and the right route. According to Lippincott Nursing Procedures, Seventh Edition, 2016, section entitled, Oral Drug Administration, steps in the implementation of medication administration included but were not limited to: Verify the medication is being administered at the proper time .to reduce the risk of medication errors. No further information was provided. COMPLAINT DEFICIENCY 31199

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, clinical record review, and facility record review, the facility staff failed for 1 resident (Resident #119) to provide the resident with a discharge plan that met the needs of the Resident, in a survey sample of 60 Residents. The facility failed to involve, evaluate, and provide Resident #119 with an interdisciplinary discharge plan. No community services were planned, no written discharge instructions were planned, nor given to the Resident, and no medical equipment was obtained for discharge home. The Findings included: Resident #119 was admitted to the facility on [DATE] and discharged home on 7-8-22 (6 weeks later). Resident #119's diagnosis included; Heart disease, Heart Failure, Diabetes, chronic kidney disease, stroke, obesity, a sacral pressure sore, and hypertension. The most recent Minimum Data Set (MDS), which was a 30-Day Assessment was reviewed and coded Resident #119 as having intact cognition. The Resident was his own responsible party. On 9-21-22, a review was conducted of Resident #119's clinical record. The Resident discharged home on 7-8-22. There was no record of discharge planning, no discharge plan completed in the care plan nor in the therapy notes, and the doctor and therapists were notified after the Resident was discharged that he had been discharged . The last nursing progress note prior to discharge was written by the day shift nurses on 7-7-22 at 1:40 PM, and 2:30 p.m., stating that the Resident had changed rooms (no documented reason was given), and that no new skin issues were assessed, and healed. The Resident had 2 pressure areas which were not healed. No location for the nursing assessment of healed, was given. On 9-21-22 Physical therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) notes were reviewed and revealed that on 7-7-22 Resident #119 has progressed with all 3 therapies and improvements were noted, however, the Resident required more time in therapy to reach the goals to move home safely. The Resident required minimal assistance with dressing, moderate assistance with toileting, contact guard assist with transfering to a toilet from a wheel chair using a scooting/bridging/sliding technique with a walker. The Resident was receiving therapy instruction on safe techniques with adaptive equipment for bed mobility, balance, energy conservation, safety in transitional movements, and safe use of durable medical equipment that would be needed/ordered upon discharge. The Resident was documented as continuing to have difficulty with peri care (incontinence care). On 7-7-22 the therapy evaluations stated that continued therapy was needed to reach goals of limited assistance needed at home, and were recommended to be continued 5 times per week, for 4 more weeks to meet goals to return home. The Resident lived alone and had only Friends who lived 30-35 minutes away from the Resident and would only be Stopping by at times to assist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident was documented as stating that when a date for discharge was planned he would contact his middle son to fly in from California to assist him upon his discharge. This indicated that home health would also be necessary upon discharge. The projected insurance date for discharge at that time was 7-14-22, and another application to the Resident's insurance would be needed to extend his Rehab time. No further therapy nor insurance communication was documented by the facility regarding this Resident and an interview with the Social Worker was requested by surveyors. On 9-21-22 an interview with the Social worker was conducted and revealed that the Regional Insurance Case Manager for the facility's parent company did not submit for further stay insurance authorization for Resident #119, and he was notified on 7-7-22 that his room would change and he would need to pay for the stay out of pocket as his insurance coverage would end on that very day (7-7-22). The Resident stated he needed home health and medical equipment and he would have to discharge as he was unable to pay out of pocket for the stay. Resident #119 discharged in a Taxi cab he called for himself, without a discharge plan, or home health services, or medical equipment to travel from [NAME] Virginia to Maryland alone on 7-8-22. Facility documents were reviewed and revealed that on 6-30-22 the Regional Insurance Case Manager for the facility's parent company corresponded via email with the Rehabilitation Director, and asked what support the Resident would require as to home health upon discharge. The email was forwarded to the Social Services Assistant who replied that Resident #119 would be moving home alone to Maryland and would need home health services. The Resident stated he would need to be ambulating well so that he could do his stairs safely at home. The resident required (2) 2 wheeled walkers, one for upstairs and 1 for downstairs, a raised toilet seat, a hospital bed, and a wheelchair. The final documentation in the clinical record was written on 7-12-22 (4 days after the Resident discharged) by the Social worker in a progress note which stated the Resident left AMA (against medical advice). The facility policy on discharge (D/C) planning was requested and received. The policy stated the following; The discharge process will begin with 72 hours of admission, planning will involve residents needs for assistance with activities of daily living, meals, ambulation, transportation medications, primary care physician follow up, home health, home care, outpatient/community outreach services. The resident and or their representative will be active participants in the D/C planning process. The plan will be reviewed by the Resident or representative weekly and Social services will update the plan. Within 6 days of discharge the Social Services Department will ensure all portions of the plan are completed, and after completion the plan will be printed and signed by the Resident or representative. A copy of the signed plan will be kept in the medical chart and a copy will be given to the Resident or Resident representative. There was no discharge plan completed in the clinical record, there was no discharge plan in the care plan, and no discharge recapitulation of stay was in the clinical record from the physician. The Administrator and Director of nursing were asked for these documents, and stated there are none. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9-21-22 at the end of day debriefing the facility administration was made aware of the deficient practice. They stated they had nothing further to provide.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, clinical record review, and facility record review, the facility staff failed for 1 resident (Resident #119) to provide a recapitulation of the Resident's stay upon discharge, in a survey sample of 60 Residents. The facility failed to document a recapitulation of the Resident's stay in the clinical record after his discharge. The Findings included: Resident #119 was admitted to the facility on [DATE] and discharged home on 7-8-22 (6 weeks later). Resident #119's diagnosis included; Heart disease, Heart Failure, Diabetes, chronic kidney disease, stroke, obesity, a sacral pressure sore, and hypertension. The most recent Minimum Data Set (MDS), which was a 30-Day Assessment was reviewed and coded Resident #119 as having intact cognition. The Resident was his own responsible party. On 9-21-22, a review was conducted of Resident #119's clinical record. The Resident discharged home on 7-8-22. There was no record of discharge planning, no discharge plan completed in the care plan nor in the therapy notes, and the doctor and therapists were notified after the Resident was discharged that he had been discharged . On 9-21-22 Physical therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) notes were reviewed and revealed that on 7-7-22 Resident #119 has progressed with all 3 therapies and improvements were noted, however, the Resident required more time in therapy to reach the goals to move home safely. The Resident was receiving therapy instruction on safe techniques with adaptive equipment for bed mobility, balance, energy conservation, safety in transitional movements, and safe use of durable medical equipment that would be needed/ordered upon discharge. The Resident was documented as continuing to have difficulty with peri care (incontinence care). On 7-7-22 the therapy evaluations stated that continued therapy was needed to reach goals of limited assistance needed at home, and were recommended to be continued 5 times per week, for 4 more weeks to meet goals to return home. Therapists also indicated that home health would also be necessary upon discharge. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9-21-22 an interview with the Social worker was conducted and revealed that the Regional Insurance Case Manager for the facility's parent company did not submit for further stay insurance authorization for Resident #119, and he was notified on 7-7-22 that his room would change and he would need to pay for the stay out of pocket as his insurance coverage would end on that very day (7-7-22). The Resident stated he needed home health and medical equipment and he would have to discharge as he was unable to pay out of pocket for the stay. Resident #119 discharged in a Taxi cab he called for himself, without a discharge plan, or home health services, or medical equipment to travel from [NAME] Virginia to Maryland alone on 7-8-22. Facility documents were reviewed and revealed that on 6-30-22 the Regional Insurance Case Manager for the facility's parent company corresponded via email with the Rehabilitation Director, and asked what support the Resident would require as to home health upon discharge. The email was forwarded to the Social Services Assistant who replied that Resident #119 would be moving home alone to Maryland and would need home health services. The Resident stated he would need to be ambulating well so that he could do his stairs safely at home. The resident required (2) 2 wheeled walkers, one for upstairs and 1 for downstairs, a raised toilet seat, a hospital bed, and a wheelchair. The final documentation in the clinical record was written on 7-12-22 (4 days after the Resident discharged) by the Social worker in a progress note which stated the Resident left AMA (against medical advice). The facility policy on discharge (D/C) planning was requested and received. The policy stated the following; The discharge process will begin with 72 hours of admission, planning will involve residents needs for assistance with activities of daily living, meals, ambulation, transportation medications, primary care physician follow up, home health, home care, outpatient/community outreach services. The resident and or their representative will be active participants in the D/C planning process. The plan will be reviewed by the Resident or representative weekly and Social services will update the plan. Within 6 days of discharge the Social Services Department will ensure all portions of the plan are completed, and after completion the plan will be printed and signed by the Resident or representative. A copy of the signed plan will be kept in the medical chart and a copy will be given to the Resident or Resident representative. A recapitulation of the stay would be documented in the medical record. There was no discharge plan completed in the clinical record, there was no discharge plan in the care plan, and no discharge recapitulation of stay was in the clinical record from the physician. The Administrator and Director of nursing were asked for these documents, and stated there are none. On 9-21-22 at the end of day debriefing the facility administration was made aware of the deficient practice. They stated they had nothing further to provide.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 40452 Based on observations, staff interviews, clinical record review, and facility documentation review, the facility staff failed to provide necessary care and services to ensure Residents have the means to communicate with others for 3 Residents (Resident #78, Resident #318, Resident #34) in a sample size of 60 Residents. The findings included: 1. For Resident #78 (whose primary language is not English), the facility staff failed to provide interpretive services as a means to effectively communicate. On 09/12/2022 at 12:45 P.M., Resident #78 was observed in bed awake. When I asked if she had any concerns about the care received at the facility, Resident #78 motioned to their neck and pointed to her roommate, Resident #38. Roommate (Resident #38) stated that [Resident #78] cannot speak but responds to yes/no questions. The Roommate (Resident #38) also stated that [Resident #78]'s primary language is not English. This surveyor observed there were no communication aids in the room and no information about a language line was observed. The roommate (Resident #38) was asked if staff used interpreter to communicate with Resident #78, and the roommate stated staff sometimes ask her to interpret because she can also speak Resident #78's primary language. When asked what she is asked to interpret, the roommate Resident #38 stated, I let them know what food she doesn't like or I let them know when she has an upset stomach. On 09/13/2022, Resident #78 clinical record was reviewed. Under the Assessment tab in the electronic health record, there was no evidence Resident #78's understanding of the English language was assessed. According to the Face Sheet under the section Primary Language, it was documented, English. According to the Admission Evaluation dated 09/13/2017 under the section entitled, Communication, the choices were English or Other. The option Other was selected and Spanish was written in the text box. A focus on the care plan initiated on 09/20/2017 entitled, [Resident #78] has a communication problem r/t Expressive Aphasia, Language barrier, Anarthria and dysarthria documented the following interventions: Anticipate and meet needs. Be conscious of resident position when in groups, activities, dining room to promote proper communication with others. Ensure/provide a safe environment: Call light in reach, adequate low glare light, Bed in lowest position and wheels locked, Avoid isolation. Another focus on the care plan was entitled, [Resident #78] is a native (Chilies, Mexican, etc.) and English is the her [sic] second language. The language barrier may limit participation during programs. Interventions associated with this focus were the following: Assess previous and current leisure interests and lifelong routines. [Resident #78] enjoys attending religious services and will be added to church list .Invite, remind and encourage to activities of stated interests as requested and tolerated. Offer and support according to needs and preferences: (life review activities, quality time with chosen relatives, friends, staff, other residents, spiritual support, touch, massage, music of preference, reading aloud, reading of preference, etc.). Offer social, recreational and volunteer visits within her tolerance and preferences. Provide and review monthly calendar with resident, offer alternatives that can be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	done individually. Provide one-on-one visits (in the room, at bedside, etc.) to stimulate senses and provide contact, target supportive programs such as (listening to relaxing music, hand massage, relaxation techniques). Respect her right to refuse groups and set own leisure routine. Staff will invite, remind and escort to programs of interests. Another focus on the care plan dated 04/25/2022 entitled, [Resident #78] has a communication problem r/t [related to] other disease process / condition had the following interventions: Observe effectiveness of communication strategies and assistive devices. Observe for declines in communication. Observe/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed. There were no interventions on the care plan addressing how to effectively communicate with Resident #78. On 09/14/2022 at 9:30 A.M., this surveyor observed Licensed Practical Nurse H (LPN H) administer medications to Resident #78. As this surveyor and LPN H entered the room, Resident #78 grimaced, held up 2 fingers, then pointed to her abdomen. As LPN H offered the Colace (a laxative), Resident #78 motioned with her hand and shook her head no. LPN H spoke to Resident #78 in English and asked Resident #78 if she was having loose stools and Resident #78 nodded her head yes and held up 2 fingers. LPN H asked Resident #78 if she had 2 loose stools and Resident #78 nodded her head yes. LPN H returned to the medication cart after the med pass and stated to this surveyor that Resident #78 had anti-diarrheal available to administer as needed. When asked how staff communicate with Resident #78, LPN H stated that staff don't use an interpreter because [Resident #78] cannot speak and she understands English. LPN H then approached Certified Nursing Assistant H (CNA H) and asked if Resident #78 had loose stools this day. CNA H stated that Resident #78 has not had a bowel movement this day. When asked how staff communicate with Resident #78, CNA H stated, We've been around her a long time; we just know what she is saying. LPN H then saw the nurse practitioner (Employee FF) in the hall and informed her of the loose stools. The nurse practitioner then started walking toward Resident #78's room. This surveyor asked to observe the nurse practitioner interact with Resident #78. The nurse practitioner stated, Do you have to be there? I'll be asking [Resident #78] a lot of questions. The nurse practitioner then turned to the nurse (LPN H) and stated she would need an interpreter. LPN H walked down to the nurse's station to ask the unit manager about an interpreter. LPN H returned and stated that the unit manager, Registered Nurse C (RN C), went to the basement to get an interpreter. On 09/14/2022 at 10:15 A.M., the Assistant Director of Nursing, RN E, was interviewed. When asked how staff communicate with Resident #78, the Assistant Director of Nursing (ADON) indicated she didn't know and stated Let me get that information for you. The ADON then stated that she would go to an interpretation site on the internet. At approximately 10:18 A.M., CNA O was asked how staff communicate with Resident #78 and CNA O stated that there are two housekeepers that speak the same language as Resident #78. The staff were identified and placed in staff identifier as Employee Q, a laundry aide and Employee R, a housekeeper. On 09/14/2022 at 10:21 A.M., LPN H provided a document entitled, Language Line with a phone number and PIN. On 09/14/2022 at 10:30 A.M., the ADON provided a copy of another document entitled, Language Line with a different phone number and PIN. The ADON stated that this was the correct one because she got it from the social worker. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/15/2022 at 9:20 A.M., Employee Q was interviewed. When asked if the staff ask her to interpret for Residents, Employee Q stated that sometimes she would interpret but I only speak alittle bit of English. When asked how often she serves as interpreter, Employee Q indicated she didn't understand the question and wanted to get her supervisor to interpret the question. On 09/15/2022 at 9:30 A.M., Employee R was interviewed. When asked if staff ask her to interpret, Employee R stated that the nurses ask her to interpret. Employee R also stated that she is not fluent in English but understands a little bit. When asked which Residents she serves as interpreter, Employee R stated Resident #78's name and Resident #6 in the sample. Employee R stated that sometimes Resident #6 will say she has pain in her leg or hip. Employee R stated Resident #6 speaks no English. When asked about Resident #78, Employee R stated that when she is interpreting for Resident #78, sometimes she will need medication. Employee R stated that Resident #78 Doesn't talk, only answers yes/no questions. I will ask her questions and she will answer. Employee R stated that she interprets when the doctor is seeing her and sometimes the nurses will ask me to go in there and check on her. On 09/15/2022 at approximately 6:45 P.M., the Administrator and Director of Nursing were notified of findings. On 09/20/2022 at approximately 10:35 A.M., Employee T, a physician, was interviewed. When asked how she communicates with Resident #78, the physician stated she asks the roommate to interpret sometimes or usually a maintenance person will do it. The physician also stated that she can speak a little bit of Resident #78's language but it was more difficult to understand her. The physician stated that Resident #78 points things out .points to things. When asked how long she had been caring for Resident #78, the physician indicated she has been seeing Resident #78 for 2 years. On 09/21/2022 at approximately 3:45 P.M., a copy of the facility's communication policy was requested and the Corporate Clinical Registered Nurse, Employee D, stated that they do not have a communication policy. The facility staff provided a copy of their policy entitled, Resident Rights. In Section (II)(a)(vii), it was documented, Residents have a right to: receive proper medical care including but not limited to: To be fully informed about their total health status in a language the resident understands. 2. For Resident #318 (whose primary language is not English), the facility staff failed to provide interpretive services as a means to effectively communicate. On 09/12/2022 at 3:50 P.M., Resident #318 was observed awake in her bed. When asked if she had any concerns about the care received at the facility, Resident #318 spoke in a foreign language. There were no communication aids or language line number observed at the bedside. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/13/2022, Resident #318's clinical record was reviewed. Under the Assessment tab in the electronic health record, there was no evidence Resident #318's understanding of the English language was assessed. According to the Face Sheet under the section Primary Language, it was documented, Hindi. According to the Admission Evaluation dated 08/31/2022 under Section 5 entitled, Is English primary language? the answer no was selected. In Section 5a entitled, Primary Language it was documented, Paru. Under the Miscellaneous tab in the electronic health record, there was a scan entitled, Admission info. A document form another facility entitled, Admission Record Report documented that Resident #318's primary language was Farsi. Resident #318's care plan did not have a focus, goals, or interventions addressing Resident #318's primary language and communication management to effectively communicate with Resident #318. On 09/21/2022 at 9:55 A.M., Resident #318 was observed with a visitor at the bedside. The visitor indicated she was a family friend and visits often in the morning-time. When asked about Resident #318's primary language, the family friend stated Urdu. When asked about Resident #318's ability to understand/communicate in English, the family friend stated that Resident #318 understands some English, but not everything. The family friend also stated that Resident #318 can speak a few words in English. When asked how the staff communicated with Resident #318, the family friend stated she didn't know because they're not here when I'm here. On 09/21/2022 at approximately 10:00 A.M., Certified Nursing Assistant W (CNA W) was interviewed. CNA W verified she was assigned to care for Resident #318. When asked for Resident #318's primary language, CNA W indicated she didn't know. CNA W then stated that Resident #318 sometimes speak English but she is not fluent. On 09/21/2022 at approximately 10:05 A.M., Registered Nurse D (RN D) was interviewed. RN D verified she was assigned to care for Resident #318 this day. When asked for Resident #318's primary language, RN D stated that she didn't know and added that she doesn't speak much English. When asked how she communicates with Resident #318, RN D stated that she understands when we talk with her. RN D also stated that the family friend that visits in the morning will help as well. On 09/21/2022 at approximately 4:15 P.M., the Administrator and Director of Nursing were notified of findings. 40026 3. For Resident #34 the facility staff failed to provide adequate means for communication for a non-English speaking Resident who has suffered a stroke. On 9/12/22 at approximately 2:00 PM an interview was conducted with Resident #34's son. Resident #34's son stated that his father did not speak English. When asked how he communicates with the facility staff he stated, he doesn't. He stated that he has to speak for his father because his father cannot speak English. When asked if they had given the Resident some kind of pictures to show what he needs like food, drink, or toilet. He stated that he has been in the facility every day and has not seen anyone use communication board since his admission on 5/23/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/14/22 an interview was conducted with CNA F who stated that she knows the Resident doesn't speak English but she goes in and cleans him up and feeds him. When asked how they know what he wants or if he needs a nurse she stated she has not come upon that situation, but if he were in distress or pain she would notify the nurse. On 9/14/22 at approximately 2:30 PM an interview was conducted with LPN D who stated that if she had a patient that could not speak English, she would use translator phone number. When asked how she would know what language the Resident spoke she said it's in the admission paperwork and it should be in is care plan. On the morning of 9/15/22 an interview was conducted with the DON who was asked what they would do if a Resident did not speak she stated they would use a communication board with pictures to identify needs such as water, toilet, and food. When asked if Resident #34 was provided such she stated that she did not know. When asked for a facility policy on Communication she stated we don't have one, however the Resident Rights Policy read: Page 3 Residents have the right to: vii. Receive proper medical care including but not limited to: 1. To be fully informed about their total health status in a language the resident understands On 9/15/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40452 Based on observations, Resident interviews, staff interviews, clinical record reviews, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide necessary services to maintain grooming and personal hygiene for 3 Residents (Resident #38, Resident #34 and Resident #35) in a sample size of 60 Residents. The findings included: 1. For Resident #38, the facility staff to provide showers for her in August and September 2022 which was her personal preference. On 09/13/2022, the facility staff provided a copy of their policy entitled, Routine Resident Care. In Section (3)(a)(b)(i)(1) documented, Provide routine daily care by a certified nursing assistant under the supervision of a licensed nurse. (b) Routine care by a nursing assistant includes but is not limited to the following (i) assisting or provides for personal care (1) bathing. On 09/20/2022 at 11:30 A.M., Resident #38 was interviewed. When asked about receiving assistance with bathing, Resident #38 stated she gets bed baths but would really prefer a shower. Resident #38 stated she had not received a shower in a long time. Resident #38 pointed to the sign on the wall which indicated her shower days should be Monday and Thursday in the afternoon but they don't do it. On 09/21/2022, Resident #38's clinical record was reviewed. Resident #38's quarterly Minimum Data Set with an Assessment Reference Date of 07/16/2022 coded the Brief Interview for Mental Status as 13 out of 15 indicative of intact cognition. Resident #38's care plan was reviewed. A focus entitled, [Resident #38] ADL Self Care Performance deficit, requires assistance with ADL Function Deficit included was not limited to the following intervention: Resident requires assistance with bathing, shower, bed bath. The care plan did not address Resident #38's preference or schedule for showers. According the Activities of Daily Living (ADL) flowsheet for the month of August 2022, Resident #38 received 6 bed baths and one shower. For the month of September 2022 up through 09/19/2022, Resident #38 received 5 bed baths and no showers. On 09/21/2022 at approximately 4:15 P.M., the Administrator and Director of Nursing (DON) were notified of findings. The DON stated the expectation is that residents would receive a bed bath daily and she would look into Resident #38 receiving showers. 40026 2. For Resident #34 the facility staff failed to provide adequate and timely feeding assistance and incontinence care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/22 at approximately 2:00 PM Resident #34 was observed in bed resting with his eyes closed he was dressed in a hospital gown and his hair appeared greasy, the head of bed was elevated and a family member at his bedside. At that time an interview was conducted with Resident #34's son. Resident #34's son stated that his father did not speak English. When asked how he communicates with the facility staff he stated, he doesn't. He stated that he has to speak for his father because his father only speaks Korean. He stated his father was completely dependent on staff for all aspects of his daily care. Resident #34's son stated that on more than one occasion he has come in to find his father soaking wet including the sheets. He stated that on many occasions he has come in hours after the meal to find the food tray sitting on the bedside table untouched because his father cannot feed himself. He further stated that he once found the call bell draped over the light above his bed out of his reach. He stated that he reported this to the DON who came in and yelled at the CNA responsible. Resident #34's son stated this made him feel uncomfortable about leaving his father alone at the facility, and is currently seeking out another facility for his father due to the lack of adequate care. On 9/20/22 at approximately 3:00 PM an interview was conducted with CNA D who was asked how often residents receive showers she stated twice a week. When asked how this was documented she stated in Point of Care (electronic health record). When asked what about if a Resident does not get shower just a bed bath, is that only twice a week as well, she stated if a shower is not given twice a week the Resident should be given a daily bed bath. On 9/20/22 a review of the ADL record revealed that Resident had 3 bed baths in last 30 days. On the afternoon of 9/15/22 the Ombudsman met with the Survey Team and she discussed her observations of the lack of cleanliness of the facility and her observations of Residents receiving inadequate incontinent care. The following are some excerpts from that interview: Yesterday I was in visiting [Resident # 57 name redacted], she was uncomfortable, she was laying on a blanket all crumpled up. Someone had thrown a fitted sheet on top of the soiled sheet and the fitted sheet was also soiled. This was about 4:30 PM. I stayed while they fixed it. When asked if she sees that kind of thing frequently at this facility she said Yes, unfortunately I do. On 9/20/22, during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 41449 3. Resident #35, who required staff assistance, was not assisted by facility staff to shave following his request. On 9/13/22 at 8:15 AM, during an interview with Resident #35, the Resident asked, What do you have to do to get a shave around here, do I need to arrange for my wife to take me to the barber? Surveyor B let LPN B know of Resident #35's request to be shaved. LPN B said she would let the CNA know. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor B then saw the assigned CNA, CNA H and let her know of Resident #35's request to be shaved. On 9/13/22, at 9:28 PM, Resident #35 was observed sitting on the edge of his bed. Surveyor B went in and talked with Resident #35 and observed that he had not been shaved as he had previously requested. On 9/14/22 at 9:30 AM, Resident #35 was visited in his room. Resident #35 identified CNA D by first name and said she had shaved him that morning. On 9/14/22 at approximately 9:40 AM, an interview was conducted with LPN B. When asked when Residents are shaved, LPN B said, During their shower, upon request or as needed. On 9/14/22 at approximately 9:45 AM, an interview was conducted with CNA E. CNA E was asked about the schedule for shaving Residents. CNA E said, There is no schedule, we shave everyday. The facility policy titled, Routine Resident Care was reviewed. This policy read, It is the policy of this facility to promote resident centered care by attending to the physical emotional, social, and spiritual needs and honor resident lifestyle preferences while in the care of this facility .3. b. Routine care by a nursing assistant includes but is not limited to the following: i. Assisting or provides for personal care . On 9/14/22, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the facility staff not assisting Resident #35 with shaving after his request was made known to two nursing staff. The DON stated, When they give a shower they shave them or as needed. Upon request if they request it, the CNA would finish what they are doing and then shave the Resident or at least on that shift. This is not acceptable at all, I'm starting to hold people accountable right now! No additional information was provided. 31199

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on staff interview, family interview, and clinical record review, the facility staff failed to ensure the highest practicable well being. for two residents (Residents # 217 and #23) in a survey sample of 60 residents. Findings: 1. For Resident #217, the facility staff failed to ensure the highest practicable well being resulting in Harm. Resident #217 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Asthma, Congestive Heart Failure (CHF), Chronic Kidney Disease Stage 3, Hypertension, Atrial Fibrillation, Obstructive Sleep Apnea (OSA), Infection due to Multi-resistant organism, and Morbid Obesity with BMI (Body Mass Index) ,d+[DATE]. Review of the clinical record was conducted on [DATE]-[DATE]. Documentation in the hospital records on Admission to the facility showed orders for a Carbohydrate Controlled Diet and Glucerna Shake. Both of these were indications that Resident #217 might have been a Diabetic. Review of the electronic clinical record revealed there was no documentation of a diagnosis of Diabetes listed in the record. There was no documentation of an order for the medication, Metformin. Review of the listed diagnoses did include Hypertension (high blood pressure) and Kidney failure. Review of the Nurses Notes revealed documentation of Shortness of breath, Blood pressure of ,d+[DATE], Pulse 126 irregular, new onset, Temperature 97.4, 02 (Oxygen saturation)- 95 %, Review of the eInteract form (communication form) dated [DATE] at 6:18 p.m. revealed documentation that Resident #217 was transferred to the hospital for Shortness of breath, wheezing and was on 5 liters of oxygen. Review of the Skin and Wound note Wounds - RLE with large intact and open blister wounds. Right lower leg surgical wound dehiscence. Sacrum and perineum with denudement and fungal dermatitis, MASD (moisture associated skin damage), . Lymphedema and Hyperkeratosis to BLE. See TA documentation for full wound assessment details. PRIMARY DIAGNOSIS ICD 10 - General Xerosis: L85. 3 - Wound, Lower Extremity Unspcfd Wnd RLE Init: S81.801A - ICD 10 - L22. - Diaper dermatitis - S80. 821A - Blister (nonthermal), right lower leg, initial encounter (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Progress Notes revealed a note written by the Nurse Practitioner on [DATE] at 16:22 (4:22 p.m.) which stated Resident # 217 was seen for complaints of increased edema and blisters. The resident was noted to have wheezing on examination by the Nurse Practitioner. The note included the following excerpt Noted to be having wheezing, SOB and increased work of breathing. Sat 87% on room air with abdominal breathing. The note also included the following Assessment and Plan: Acute Respiratory Failure with Hypoxia, Placed on 5 liters of Oxygen, nebulizers were given , placed on CPAP temporarily. if not improvement in dyspnea may need ER evaluation On [DATE] at 16:50 (4:50 p.m.),nurse documented Resident # 217 was alert and oriented x 3, had 3 + (3 plus) edema on bilateral lower legs, blisters, redness, warmth to the right lower leg, DTI to the sacrum, and redness and rash to the peri area. Wound nurse notified, Nurse Practitioner notified, son notified. Interview conducted on [DATE] with the Director of Nursing who stated she did not see a diagnosis of Diabetes for Resident #217 in the clinical record. The Director of Nursing stated the facility staff normally would review the hospital records upon admission to the facility. Any diagnoses would be carried over to the Admission Notes. An interview was conducted with the Responsible Party via telephone on [DATE] at 9:31 a.m. Resident #217's son stated the resident had been a known Type 2 Diabetic for over [AGE] years and had been taking Metformin. He stated the resident was aware of the diagnosis and that she told the staff that she was a Type 2 Diabetic. He stated medications were given by staff who did not explain what each pill was being taken for. Resident # 217's son stated that during the pandemic, we could not advocate for her. We could not see her. We had to trust what the facility was telling us. That started a lot of the problems. We could not see what was happening. We did not get answers from the staff when we called to express our concerns. Review of the Hospital Discharge Records dated [DATE] revealed no diagnosis of Diabetes in the list of diagnoses. Further review of the documents revealed documentation of an order for a Carbohydrate Controlled Diet and Glucerna. According to the American Diabetes Association, the Carbohydrate Controlled Diet Helps people with diabetes keep their carbohydrate consumption at a steady level, through every meal and snack. On [DATE] at 11:15 a.m., an interview was conducted with the Director of Nursing regarding Admission History and Physicals. The Director of Nursing stated the doctors come on Mondays and Fridays to review new admissions, review the history and physical, do the initial History and Physical on Admission usually on Mondays or Tuesdays. The Director of Nursing stated the Nurse Practitioner are in the facility Monday through Friday. We have two Nurse Practitioners who come to the facility. One just started recently. On [DATE] at 6:27 PM, a message was left on the telephone voicemail for the Medical Director . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	The Medical Director immediately returned the telephone call at 6:28 PM. An interview was conducted over the phone with the call on speaker phone with all 6 surveyors present. The Medical Director stated he was aware that the facility was being surveyed during the past week and that the surveyors were back to complete the survey. The Medical Director stated he had been out of town at a meeting in Richmond and was going out of town for the next 10 days. The Medical Director was asked about the process for obtaining history and physical information on new admissions to the facility. The Medical Director stated one of the three physicians who see residents in the facility. The Medical Director stated the facility accepts the patients. We (doctors) don't decide who gets admitted . The facility knows what they can do. The Administrative team makes the decision about who gets admitted . When asked about the process of determining chronic disease diagnoses, the Medical Director stated we look at the records from the hospital. The hospital has their history. It's their responsibility to obtain an accurate history. We have the patient for Physical Therapy. We have them for a short time. If there are signs and symptoms, we would check labs. Then the Medical Director questioned the surveyor Why don't you ask the Hospital why they didn't do it? They are supposed to do a medical history. We review that history. It is not standard of practice to check A1C on residents or check for Diabetes unless they have a history or have medicine for Diabetes. We review the hospital records, examine the patient and look at the medicines. I've worked in the hospital before. The hospital is supposed to check the medical history. They do lab work there routinely. We don't routinely do labs for rehab patients unless they have signs and symptoms. When asked if a Blood Glucose result of 145 was considered an indication of a need for further follow up, The Medical Director stated it depends on whether the resident was fasting or nor. An A1C (Hemoglobin A1C) is not indicated unless there are signs or symptoms of Diabetes. The Medical Director was asked if a resident 5 foot 3 inches tall weighing over 370 pounds was a person that might need close follow up to determine if there was Diabetes. The Medical Director again stated that the facility would check the hospital records to see if there was a previous diagnosis of Diabetes. The Medical Director was asked about Residents with Diabetes who were managed by Diet alone or what if the hospital did not obtain a complete medical history. The Medical Director again stated the hospital was supposed to obtain the medical history and the facility would review those documents to obtain the information. The Medical Director was asked if the facility staff ever contacted the Primary Care Physician to make sure an accurate history was obtained. The Medical Director stated no. When the Medical Director was informed that Resident #217 had a Blood Sugar of 844 that was obtained at the facility but not resulted out until after the transfer to the hospital., the Medical Director stated that could have been an acute thing. It could have just happened. She had no signs or symptoms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	The Medical Director was asked if he thought there was a potential for important diagnoses to be missed if the facility staff was relying on the discharging hospital to provide all of the history and physical information. The Medical Director stated the hospital was supposed to be obtain a complete history and physical and the facility would review that information when the resident was admitted to the facility. He then stated the nursing staff would ask information during the admission assessment but would use the hospital discharge summary. The physician at the facility would examine the resident and interview them about the medical history. On [DATE] at 10:45 a.m., another surveyor interviewed one of the physicians (Employee T) about another resident in the survey sample. Employee T was listed on the hospital discharge Summary (and in the clinical record) as the Primary Care Provider for Resident #217. This surveyor immediately asked the Regional Nurse Consultant to have Employee T to call this surveyor. The Regional Nurse Consultant stated Employee T had already left the facility but a message had been left for her to call the surveyor. The Regional Nurse Consultant stated she spoke with Employee T and that Employee T checked her records mentioned something about Diabetes and noted that Resident #217 had not been her patient anymore for 3 years but may have been seen by one of the partners in the group. Requests were made to have the physician (employee T) to call this surveyor. The Regional Nurse Consultant stated the physician wanted to make sure the family gave permission for her to talk with the surveyors due to HIPPA. This surveyor informed the Regional Nurse Consultant that the Resident's son was aware and told the surveyor to call the Primary Care Doctor to gather information. Employee T never returned the call to the surveyor. Several attempts to reach the physician (Employee T) were unsuccessful while on survey. On [DATE] at 11:45 a.m., an interview was conducted with the Regional Nurse Consultant who stated she reviewed the clinical record and could not find any documentation that Resident #217 had Diabetes. She stated she did find evidence of an order for a Diabetic Diet and Glucerna on the hospital discharge records in [DATE] that were used for admission to the facility. The Regional Consultant stated that when the labs were ordered and results came back, Resident #217 was already in the hospital. The Regional Consultant stated we probably should have been checking the blood sugar due to the Diet Order and the Glucerna which are both used for Diabetes. That was a clue She also stated the facility staff should do a thorough History and Physical to include interviewing the resident, family members and the Primary Care physicians. The family should be asked about past medical history too. Review of the Blood Sugar Review of the Blood Sugar readings revealed documentation of two elevated Comprehensive Metabolic Profile blood sugar results in [DATE]. There were no other Blood Glucose results noted that were drawn after the level of 145 in [DATE] in the clinical record. According to the lab report, normal range is less than 110. There was no noted follow up to check the Hemoglobin A1C after the documented elevated blood glucose level. [DATE]- CMP-blood glucose level 118 [DATE]-CMP-blood glucose level 145 [DATE]-CMP-blood glucose level 844 There was no documentation of a Hemoglobin A1C being ordered for Resident #217. The A1C evaluates the amount of glucose in the blood over the last two to three months. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident #217 had several risk factors that would indicate a work up or evaluation for Diabetes including age, race, BMI greater than 60 and elevated blood glucose levels on routine lab work while in the facility. Resident #217 was alert and oriented. According to Resident #217's son, Resident #217 stated 'that;s a lie, I told them. There was no documentation that the facility staff asked questions about a previous history of Diabetes. The was no was documentation that anyone assessed the clinical picture of told about the diagnosis When Resident #217 was transferred to the hospital on [DATE], the Blood Sugar was 844. Resident #217 was immediately taken to the Intensive Care Unit and stayed for a few days. Upon discharge from the hospital, Resident #217 went to another facility because she refused to return to the facility. He stated Resident #217 had to have a partial amputation while in the hospital. The numbers were not right. So, they could not do the entire amputation. He stated Resident #217 had to be hospitalized again and had pneumonia, COVID and 'Kidney Failure. The resident expired in [DATE]. 40452 2. For Resident #23, the facility staff failed to provide a left upper extremity device on [DATE] as recommended by the therapy department. On [DATE] at 2:55 P.M., Resident #23 was observed in her bed. Resident #23 had a contracture of her left upper extremity and there was no positional device observed. At approximately 2:57 P.M., Certified Nursing Assistant Q (CNA Q) was interviewed. When asked about a positional device for Resident #23, CNA Q stated that Resident #23 has one but she hates it and she always throws it away.When asked where the device was located, CNA Q looked around the room and found it in the closet. CNA Q did not attempt to apply the device but put it back in the closet. On [DATE] at 3:02 P.M., the Director of Rehab was interviewed. When asked about the dates of service for therapy for Resident #23, the Director of Rehab referred to Resident #23's clinical record and stated the dates of service were [DATE] to [DATE]. When asked about therapy recommendations at the conclusion of her therapy care, the Director of Rehab stated that therapy recommended a positional device for her left upper extremity. When asked if Resident #23 tolerates the device, the Director of Rehab stated that She tolerated it really well, some days better than others. At 3:09 P.M., this surveyor and the Director of Rehab entered Resident #23's room to do an observation. The Director of Rehab retrieved the positional device from the closet and positioned it on Resident #23's left upper extremity. Resident #23 tolerated the application of the positional device. At 3:19 P.M., Resident #23 was observed awake in bed still wearing the device. On [DATE], the facility staff provided a copy of Resident #23's Occupational Therapy notes. On the Occupational Therapy Discharge Summary dated [DATE] under the header Patient Response an excerpt documented, Patient tolerating orthotics well. No large gains in ROM [range of motion] however decreased skin to skin contact and risk of skin breakdown and further contracture. Under the header, D/C Recs [discharge recommendations] an excerpt documented, placement of LUE [left upper extremity] orthotics (UE [upper extremity] device and palm protector . On [DATE], Resident #23's clinical record was reviewed. There were no physician's orders for a positional device for Resident #23's left upper extremity. The care plan was reviewed. There was no focus, goals, or interventions pertaining to Resident #23's left upper extremity contracture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at approximately 4:15 P.M., the Administrator and Director of Nursing were notified of findings. When asked about the expectation, the Director of Nursing indicated contracture management should be on the care plan. On [DATE] at 10:30 A.M., Resident #23 was observed resting in her bed with the positional device in place. On [DATE] at 10:45 A.M., the Director of Rehab was interviewed. When asked about the process for therapy recommendations upon discharge from services, the Director of Rehab stated that therapy staff will enter the orders into the electronic health record. When asked why Resident #23 did not have orders for the therapy-recommended orthotic, the Director of Rehab stated, It just got missed. Complaint related deficiency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure that Residents receive care, consistent with professional standards of practice to prevent pressure ulcers from worsening or new ulcers developing for 2 Residents (Resident #111 and 86) in a survey sample of 60 Residents, resulting in harm for Resident #111. The findings included: 1. For Resident #111, the facility staff failed to identify, treat and prevent a pressure ulcer until it was found at an advanced stage, necrotic and required sharp debridement. This constituted harm. On 9/12/22, Resident #111 was observed in his room. Resident #111 indicated that he had new wounds that were not present on admission during the interview. On 4/21/22, a Braden scale assessment was conducted that revealed Resident #111 was at moderate risk for developing pressure related skin issues. A clinical record review revealed that Resident #111 had been admitted to the facility on [DATE]. Nursing notes on admission indicated Resident #111 had a necrotic wound on his left foot. There was no mention of any other skin breakdown or ulcers. The admission MDS (minimum data set) (an assessment tool) with an assessment reference date of 4/20/22, had section M, for skin conditions coded as Resident #111 having had no unhealed pressure ulcers/injuries. Weekly skin checks completed 4/18/22, 4/25/22, 5/2/22, and 5/16/22, made no reference of Resident #111 having had any pressure ulcers or skin issues identified. The skin check completed 5/9/22, indicated Resident #111 had a wound on his left toe(s). On 5/15/22, a Skin Grid Pressure assessment was completed that revealed Resident #111 had an area identified on that date on his left gluteal fold which measured 5 cm x 2 cm x 0 cm. A nursing note was entered into the record on 5/15/22, which read, Writer was called to observed resident skin at about 3 pm. Writer notice skin ulcer and writer notified supervisor and wound nurse who was in house. Skin ulcer to left gluteal and scrotum. MD notified .[sic] On 5/16/22 at 8:56 AM, Resident #111 was seen by a wound care specialist who assessed the wound as 2. 91 cm x 2.70 cm x 0.1 cm, with 0.62 cm black tissue, 0.53 cm yellow tissue, and 40 % granulation, 30 % eschar/slough. The note went on to read, Full thickness, and wound debrided .Etiology Pressure ulcer- stage 3 . Orders for Medihoney, Calcium alginate were noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #111's care plan revealed on admission he had the following focus area, [Resident #111's name redacted] has impaired skin integrity, and is at risk for altered skin integrity. The following interventions were noted to be entered on the care plan following his admission, Administer treatments as ordered by medical provider, complete skin at risk assessment upon admission / readmission, quarterly, and as needed, Complete Weekly Skin checks. The intervention to add a pressure reducing mattress to the bed, was not added to the care plan until after the wound had been identified on 5/16/22. There is no evidence of any preventative measures being implemented to prevent the development of pressure wounds when Resident #111 had been identified to be at risk. This wound at the time of discovery had necrotic tissue that required sharps debridement, this constituted harm for Resident #111. Guidance is provided for the staging of pressure ulcers by the National Pressure Ulcer Advisory Panel (NPUAP), and is as follows; THE NATIONAL PRESSURE INJURY ADVISORY PANEL (NPIAP) provides guidance on the staging of pressure ulcers in the document titled, NPIAP Pressure Injury Stages. This document read, Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue . It goes on to state: .Stage 3 Pressure Injury: Full-thickness skin loss: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Accessed online at: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf Review of the facility policy titled, Skin Care & Wound Management Overview was conducted. This policy read, Procedure: Prevention.3. Identify diagnosis or conditions to place the resident/patient at risk for pressure ulcer development .4. Develop a care plan with individualized interventions to address risk factors. 5. Communicate risk factors and interventions to the care giving team. 6. Evaluate for consistent implementation of interventions and effectiveness at clinical meeting. 7. Modify and document goals and interventions as indicated. 8. Communicate changes to the care giving team . On 9/21/22, during an end of day meeting with the facility Administrator, Director of Nursing and Corporate staff, they were made aware of the above concerns. No additional information was provided. 40026 2. For Resident # 86 the facility staff failed to put interventions into place for a Resident that is non-ambulatory and at nutritional risk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident # 86 was admitted on [DATE] with diagnoses that included ALS, dysphasia, failure to thrive, and a peg tube had been inserted. A review of the Admission Initial Evaluation revealed that Resident #86 had one Non-Pressure Area under her left and right breast MASD this was being treated with antifungal cream. A review of the care plan revealed that Resident #86 was care planned for impaired skin integrity, or at risk for altered skin integrity. 08/12/22 upon admission [Resident #86] has MASD under L and R breast Date Initiated: 08/13/2022 The following interventions were put into place: Administer treatments as ordered by medical provider. Date Initiated: 08/13/2022 Complete skin at risk assessment upon admission / readmission, quarterly, and as needed. Complete Weekly Skin checks. Date Initiated: 08/13/2022 Resident #86's most recent MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 8/13/22, coded Resident #86 as requiring #3 Extensive Assistance with 2 person physical assistance for bed mobility and transfers. She is coded as Extensive assistance or totally dependent for all other ADL tasks requiring 1 person physical assistance. 9/3/2022 10:08 PM- Skin/Wound Note - Date of service: 08/30/2022- Chief Complaint: Comprehensive skin and wound evaluation for Sacral DTI. Past Medical, Surgical, Social and Family History: reviewed per patient's chart ALS, adult failure to thrive. Dermatologic - Wound(s) present; Please see wound assessment below. Wounds - Sacral DTI See TA (Tissue Analytics) documentation for full wound assessment details. ICD 10 Comorbidities Wound Healing Risk Factors - Function Urinary incontinence: - Fecal incontinence 9/10/22 at 10:30 AM See Tissue Analytics Documentation for full wound description and recommended nursing plan of care. I am recommending an air mattress for pressure reduction. Plan of Care Assessment & Plan - Patient has a pressure injury; Pressure reduction and turning precautions discussed with staff at time of visit recommended, including heel protection and pressure reduction to bony prominences. Staff educated on all aspects of care. On 9/14/22 an interview with LPN who stated that she follows the wound care orders after the NP sees the Residents. When asked how heel boots or air mattresses get ordered she stated that the NP who cares for the wounds will order them. When asked if the Resident was on a turning schedule to off load the pressure from her buttocks she stated that she was turned when they gave incontinence care. Wound Care NP followed resident for this wound and on 8/30/22 wrote the following on the TA Documentation to the facility: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Ensure compliance with turning protocol, Wedge/ foam cushion for offloading, Wheelchair Cushion, Specialty Bed, Dressings Collagen Ag,Secondary Dressing Bordered foam On 9/16/22 the NP wrote the following on the TA Documentation to the facility: Ensure compliance with turning protocol, Wedge/ foam cushion for offloading, Wheelchair Cushion, Specialty Bed, Dressings Skin prep,Secondary Dressing Bordered foam The care plan was not updated to include these items, and there was no physicians order for an air mattress. On 9/20/22 at the end of the meeting the DON and Administrator were made aware of the findings and no further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, Resident family interview, staff interview, clinical record review and facility documentation review, the facility staff failed to prevent the development of a contracture resulting in limited range of motion, which constituted harm, for one Resident (Resident #14) in a survey sample of 60 Residents. The findings included: For Resident #14 who was admitted without any contractures of her hand and arm, the facility staff failed to implement therapeutic interventions to prevent the development of contractures. As a result, Resident #14 developed contractures of her fingers, wrist and elbow, and therapeutic interventions were not initiated for over three months following the identification, this constitutes harm for Resident #14. On 09/12/22 at 02:49 PM, Resident #14 was visited in her room and a family member was at the bedside. A Resident and family interview were conducted. Resident #14's family member said he is very concerned about the Resident's left hand, she is no longer able to use it and when touched on the hand she has pain. The family member went on to say that they have talked to various staff, including but not limited to nursing and the social worker to request therapy services for several months and still nothing has been done. During the above interview, Surveyor B observed Resident #14's left hand and noted that her fingers appeared to be contracted in a closed position, her wrist appeared to have some limited movement as well. When asked if she (Resident #14) could open her hand she was not able to do so independently. Resident #14's finger nails appeared very long and were making contact with her palm which was in a closed fist position. There was no brace, wash cloth or any other device observed in her hand. A clinical record review was conducted and the following findings were noted: Resident #14 was admitted to the facility on [DATE]. Review of the admission assessment and notes revealed that upon admission Resident #14 had contractures of her lower extremities. There was no indication of her having any limitations in range of motion or contractures of her upper extremities. The most recent MDS's [minimum data set/an assessment tool] conducted 3/6/22 and 6/24/22, were reviewed. Both were coded in section G0400. Functional Limitation in Range of Motion, question G0400 A: Upper extremity (shoulder, elbow, wrist, hand): no impairment On 3/8/22, the doctor saw Resident #14 with regards to concern about rings on three fingers. The doctor assessed Resident #14's hand and made no indication that Resident #14 had any limited range of motion or contractures in her hands/arm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Actual harm Residents Affected - Few	On 3/15/22, the doctor again saw Resident #14 with regards to rings on her left hand fingers. The doctor note read, .osteoarthritis of PIP [proximal interphalangeal joints/located in fingers] and Bouchards nodules [hard, bony outgrowths or gelatinous cysts on the proximal interphalangeal joints] . The note made no indication of Resident #14 having any contractures of her wrist, elbow, or hand/fingers, and no mention of limited range of motion. On 5/17/22, the doctor saw Resident #14 and noted in the progress notes, .Son visiting patient today noted she pulls left hand away when touched in pain .Hand: no erythema or warmth and limited both active and passive extension left ____finger(s); pulls hand away when examined, has ring on2-4 fingers cannot remove as PIP joints enlarged from osteoarthritis; distal circulation intact with no erythema, no warmth no swelling . On 5/31/22, the doctor assessed Resident #14 and noted the following, .pip joints enlarged limiting ability to remove rings from left fingers 2-4- distally neurovascular intact but pulls hand away when goes to examine it - ? pain at rest or only when handled, contractures of fingers present also - has been on tramadol for pain and would continue low dose and monitor response - had discussed with son no urgency to remove rings but would have to go to ER or urgent care for removal . The MDS [minimum data set/an assessment tool] conducted 6/24/22, which was coded as a quarterly assessment was reviewed. This assessment was coded in section G0400. Functional Limitation in Range of Motion, question G0400 A: Upper extremity (shoulder, elbow, wrist, hand): no impairment On 7/1/22, an x-ray of Resident #14's left hand was performed. This x-ray was unremarkable. On 7/5/22, the doctor noted the following upon assessment of Resident #14, .Hand: no erythema or warmth and limited both active and passive extension left finger(s); has ring on 2-4 fingers cannot remove as PIP joints enlarged from osteoarthritis; distal circulation intact with no erythema, no warmth no swelling but unable to rotate rings . A physician order dated 7/13/22, that read, OT [occupational therapy] evaluation for splint for left hand contracture of fingers. A progress note written by the provider the same day read, .Assessment / Plan 1. Contracture of multiple joints- particularly left hand with apparent pain with movement and when try to examine it but seems comfortable when left alone 2. degenerative joint disease of hand - Left -has rings on 2-4 fingers not able to be removed due to osteoarthritis of pip, neurovascular intact distally no sign acute synovitis -discussed with son this evening will have OT see for possible splint to minimize movement may help with pain for care and handling of patient . A physician progress note dated 8/23/22, that read, .Follow-up: Contracture of multiple joints . Musculoskeletal System: Hand: no erythema or warmth and limited both active and passive extension left finger(s); able to move arm to examine and hand but does draw away when attempt to open fingers, rings on fingers but distal neurovascular intact. Musculoskeletal System contracture of extremities .Assessment / Plan: 1. Contracture of joint of left hand - no erythema, no warmth does pull away when attempts to move fingers - have asked OT to see patient for contracture cushion . On 8/23/22, a nursing to therapy notification was entered into Resident #14's record that read, .weakness upper/lower extremities and contractures upper/lower extremities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Actual harm Residents Affected - Few	Resident #14's care plan did not identify or address the hand/wrist and elbow contractures and therefore no interventions were put in place to prevent the development of and prevent further decline. On 9/15/22 at 9:15 AM, an interview was conducted with Employee N/the rehab director. Employee N accessed the therapy records and was asked to identify if and when Resident #14 had received therapy services. Employee N stated that she had not previously been on therapy caseload but when they screened her two weeks ago due to an upcoming MDS [minimum data set assessment] and a therapy referral being entered on 9/1/22, they determined she needed services and were planning to start therapy today or tomorrow. Employee N reviewed the physician orders and stated he was not aware of the physician order entered on 7/13/22, he said, This is the first time I'm seeing the order from July. Employee N stated, If the doctor writes and enters an order I don't get a notification. Nursing has to go in and enter a therapy referral for us to get a trigger. Employee N confirmed that Resident #14 had been screened for therapy services 5/24/22, and was at baseline with no contractures identified at that time. When asked to explain the purpose of contracture management, Employee N said, To make sure we are maintaining what has been achieved, to make sure we prevent it from getting worse, to prevent skin break down and to maintain functional activity for the Resident, comfort and prolonging the worsening. On 9/15/22, an interview was conducted with the facility social worker/Employee E. Employee E confirmed that she recalled Resident #14's family talking with her about and requesting therapy services and she had notified the rehab director. Employee E provided the survey team with a copy of an email that she sent on 8/15/22, that read, [Resident #14's name redacted] have you assess her for the hand the son was asking . On 9/15/22, the facility Administration was asked to provide a timeline with regards to Resident #14's contracture development. The facility provided copies of admission assessments which revealed the contractures were not present upon her admission to the facility and were developed/acquired in-house. On 9/15/22 at 7:20 PM, the therapy director provided the survey team with a copy of the Occupational Therapy (OT) evaluation that was completed for Resident #14 on 9/15/22. It read, .Reason for Referral: Patient is a 88 y/o [year old] female referred to skilled OT evaluation for assessment and management of LUE [left upper extremity] flexor contractures at elbow, wrist and hand due to hx [history] of R [right] intracranial hemorrhage LUE [left upper extremity] ROM [range of motion]= Impaired (L wrist rests in 80 degrees flexion with ~30 degrees of passive extension from fixed position available. L D3 [left digit 3/finger] and 4 most severe with 90 degree contractures from MCP [Metacarpophalangeal joint/commonly known as knuckles] to DIP [Distal Interphalangeal Joint/bones at the tip of the fingers]. L thumb proximal phalange in fixed adducted position with hyperextension of IP joint, unable to form functional grasp. L D2 and D5 [left digit 2 and 5/ index and pinky fingers] are least affected with resting MCP flexion at 90 degrees and ability to extend 45 degrees from this position, distal segments flaccid and passively WFL [Within Functional Limits]. L elbow passively WFL, shoulder flexion PROM [passive range of motion] 0-120 degrees and AROM [active range of motion] 0-35 degrees; patient rests in elbow flexion (~70 degrees) and internal rotation . The lack of intervention by facility staff permitted the contractures to develop and then worsen for Resident #14. This constitutes harm for Resident #14. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Actual harm Residents Affected - Few	On 9/15/22, the facility policy regarding contracture prevention and management of contractures was requested but not received prior to the conclusion of the survey. On 9/21/22, during an end of day meeting, the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings. No additional information was received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure an environment free from accident hazards for one Resident (Resident #27) of 60 residents in the survey sample. The findings included: For Resident #27 the facility staff failed to supervise a confused known fall risk resident who recently suffered facial fractures as the result of an unwitnessed fall. The Resident was in his room in a geri (reclining) chair with the bedside curtain closed obscuring the Resident from view, no fall mats in place, and his helmet off. Resident #27 was admitted to the facility on [DATE] with diagnoses including; Covid-19, Rhabdomyolysis, Dementia, psychotic disturbance, anxiety, and history of multiple falls. The Resident required total dependence on staff for all activities of daily living. The Resident was able to stand independently. On 9-15-22 at 4:00 p.m. Resident #27 was observed by 2 surveyors alone in his room. The privacy curtain had been closed and the Resident was found behind the curtain obscured from view of the hallway, between the 2 beds in the semi-private room alone. The Resident was sitting in a geri reclining chair, reclined at a 45 degree angle. There were no fall mats on the floor on either side of the chair/bed, and his helmet was on the floor beside him. The call bell was tied on the back of the chair out of his reach, and his bed was in high position beside him. The nurse at the nursing station approached the room and stated, when asked, if it was safe for the Resident to be left here alone in this way, This should absolutely not happen. Resident #27's physician orders, progress notes, and care plan were reviewed. The review revealed that Resident #27 had active physician orders for the following; 1. A sitter 1:1 for safety precautions ordered 6-22-22. 2. Wear protective helmet at all times when out of bed for safety precautions ordered 6-22-22. 3. Hospice ordered 6-29-22. Review of the Care Plan revealed documented falls in 2022 (including 3 with serious injury) on; 1-3-22, 1-8-22, 5-3-22, 6-18-22, and 8-9-22. The Resident sustained a lacerated left eyebrow on 5-3-22, and fractured zygomatic (broken nose) arch on 6-18-22, and hematomas/black right eye, bruised scalp and cheek on 8-9-22. The care plan active treatment modalities included the following active interventions to be carried out by staff; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Call bell within reach, instituted 2-22-22. 2. Monitor closely when in wheel chair with other fall risk residents, instituted 3-26-22. 3. Mattress on floor to prevent falling out of bed, instituted 3-28-22. 4. At nursing station when out of bed in wheel chair, and anti lock device to wheel chair, instituted 5-2-22. 5. Place in close observation and monitoring every shift, instituted 6-18-22. 6. 1:1 observation (sitter at all times within sight), instituted 6-19-22. 7. Apply helmet to prevent head injury related to fall, instituted 6-22-22. 8. Floor mats beside bed, non-skid foot wear, to group activities to prevent further falls, instituted 6-23-22. Upon observation of the Resident on 9-15-22 during survey none of the interventions listed were being implemented by staff for a known fall risk Resident who had sustained serious injury due to falls. Supervision was inadequate, and the Resident was at risk for an accident because of known hazards. On 9-15-22 at the end of day debrief, the Administrator and DON were notified of the above findings. The DON stated their was no further evidence to present, and stated that the Resident should not have been left alone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure services for care of a suprapubic catheter consistent with professional standards of care, the comprehensive care plan and Resident preferences for 1 Resident (#88) in a survey sample of 60 Residents. The findings included: For Resident #88 the facility staff failed to ensure proper and timely care for a suprapubic catheter (a suprapubic catheter is a tube inserted into the bladder through an incision in the abdomen, to drain urine into a collection bag.) On 9/12/22 at 12:00 PM and again on the morning of 9/13/22 Resident # 88 was observed with this suprapubic catheter collection bag hanging from the back of his wheel chair near the handle above his waist height. On 9/13/22 at approximately 10 AM an interview was conducted with Resident #88 and he was asked if it was usual practice for the staff to hang his collection bag for his catheter on the wheel chair handle and he stated that it was. On 9/13/22 at approximately 11:00 AM, during a Resident Council meeting, Resident #88 stated that call bell answer times are still an issue. He further elaborated that what the staff are doing is come by and shut light off and say they'll get your aide or say someone is coming but no one comes. If they do show up it takes a long time for them to come take care of your needs. He indicated this has been an ongoing problem. A review of the facility documentation revealed that on 8/27/22 a Training Sign-In Log was signed by 17 staff members both CNA's and Nurses, on the topics of timely answering of call bells, Perineal Care and ADL care. On 9/12/22 at approximately 12:15 PM CNA E was asked if his bag was hanging correctly and she stated it has got to be up here so it doesn't hit the floor. The following are excerpts from the NIH online article Strategies for Preventing Catheter-associated Urinary Tract Infections. [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5998608/] Strict handwashing with soap and water should be done immediately before and after any manipulation of the catheter site or device. Unobstructed flow of urine should be maintained at all times. Indwelling catheter must be properly secured to the patient's thigh to prevent urethral meatus injury. The skin condition around the catheter should be checked regularly and if skin irritation is noted the site must be changed. A sterile, closed unobstructed urinary drainage should be used with indwelling catheters. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The collecting bag should be placed below the level of the bladder and off the floor and should be kept and emptied regularly. National Institutes of Health website (https://medlineplus.gov/ency/patientinstructions/000145.htm) read: Check the catheter site a few times a day. Check for redness, pain, swelling, or pus. Wash the area around catheter every day with mild soap and water. Gently pat it dry. Showers are fine. The collecting bag should be placed below the level of the bladder and off the floor and should be kept and emptied regularly. Make sure your bag is always below your waist. This will keep urine from going back into your bladder. Try not to disconnect the catheter more than you need to. Keeping it connected will make it work better. Check for kinks, and move the tubing around if it is not draining. On the afternoon of 9/15/22 the Ombudsman met with the Survey Team and she discussed her observations of the lack of cleanliness of the facility and her observations of Residents receiving inadequate incontinent care. The following are some excerpts from that interview: Yesterday I was in visiting [Resident # 57 name redacted], she was uncomfortable, she was laying on a blanket all crumpled up. Someone had thrown a fitted sheet on top of the soiled sheet and the fitted sheet was also soiled. This was about 4:30 PM. I stayed while they fixed it. When asked if she sees that kind of thing frequently at this facility she said Yes, unfortunately I do. On 9/14/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 31199 Based on staff interview and facility documentation review, the facility staff failed to ensure that required competencies were completed for 6 of 6 nursing staff members including, Registered Nurses (RN), Certified Nursing Aides (CNA), and Licensed Practical Nurses (LPN). The survey sample of 6 consisted of; (RN/DON), (CNA B), (CNA C), (CNA F), (LPN F), and (LPN G). The Facility failed to complete required initial, and annual, competency training, and evaluations. The Findings included: On 9-14-22 a review was requested for employee education/training and competency evaluations. The facility Administrator was asked for employee records for the 6 staff members. Each day from 9-14-22 through 9-18-22 the employee records were requested, and surveyors were told by the Administrator oh yes, I have them on my desk, I will send them to your email. On 9-19-22 education records and evaluation information was received. There were 4 of the 6 included and a call was placed to the Administrator to ask for the other 2 missing documents. The Administrator stated We can find nothing for those employees. The 4 that were received stated on the email from the Administrator the following; CNA (C) (name) does not have an annual eval on file, CNA (B) (name) has none, DON (name) has none, and LPN (F) (name) we only have termination. No mention was given for the other 2 staff LPN (G), and CNA (F) which were never received. The documents were reviewed and revealed that for all 6 staff members no annual evaluations nor competency evaluations had been completed in the past year. In review of the education records received, only 3 staff members had education records. For the 3 employees who did have education records (DON, CNA (B) and CNA (C) none of them had received education in mandatory training to include the following; Preventing and reporting abuse/neglect and exploitation. Dementia care and management. Infection Control. Resident rights. Person Centered Care. Communication. Skin and wound Care. (Only the DON had training for this requirement). Medication management. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pain management. Identification of change in condition. Cultural competency. Care of the cognitively impaired resident. Implementation of care plans. On 9-20-22 Director of Human Resources (Employee X) stated the employee training records were computer-based Relias training conducted in the facility. Employee X utilized her computer to facilitate the review, and provided copies to the Administrator to forward to the surveyors. The Director of Human Resources was asked who was responsible for clinical staff training, and she stated that it was the nursing departments' responsibility to ensure that the required training was completed. She stated annual training is based on date of hire. On 9-20-22 the Administrator, and the Director of Nursing (DON) were informed of the findings. When asked about the nursing departments' responsibility to ensure that nursing staff received the required training, the DON stated, I can't tell you about all of the required training. Staff are required to complete it online. I can follow-up with the Completion Report printed from Relias. During the course of the 2 week survey deficient practice was levied at Immediate Jeopardy (IJ), and harm, in the area of abuse/neglect and exploitation, and in not providing rehabilitative services. It was also found that accident hazards existed for a demented resident, an unsafe discharge was performed for a dependant resident, quality of life was deficient, quality of care was levied at harm in 3 areas to include pressure sores and range of motion, significant medication errors were found, and notices for advocacy agencies were not posted for resident use. Residents recounted allegations of fear and retaliation during the entire survey, and facility known resident allegations of abuse had gone unreported and uninvestigated by the facility, and logged in a grievance file. The lack of training for staff competency may have contributed to these outcomes. On 9-20-22 at the end of day debrief the Administrator and DON stated that all of the staff education records they had were given to the survey team. No further information was provided by the facility at the time of exit on 9-22-22 at 4:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 31199 Based on staff interview and facility documentation review, the facility staff failed to ensure that required annual performance reviews, with in-service training based on those reviews, were completed for 3 of 3 Certified Nursing Aides (CNA) in the survey sample, (CNA B), (CNA C), and (CNA F). The Findings included: On 9-14-22 a review was requested for CNA employee Performance reviews and training records. The facility Administrator was asked for employee records for the 3 staff members. Each day from 9-14-22 through 9-18-22 the employee records were requested, and surveyors were told by the Administrator oh yes, I have them on my desk, I will send them to your email. On 9-19-22 two of the requested 3 CNA records were received. A call was placed to the Administrator to ask for the other missing documents. The Administrator stated We can find nothing for that employee. The 2 that were received stated on the email from the Administrator the following; CNA (C) (name) does not have an annual eval on file, CNA (B) (name) has none, and no mention was given for the other CNA (F), which was never received. The documents were reviewed and revealed that for all CNA staff members no annual evaluations nor competency evaluations had been completed in the past year. In review of the education records received, only 2 of the 3 requested staff members had education records. For the 2 CNA's who did have education records (CNA (B) and CNA (C) neither of them had received an employee performance review and so training needs would not have been known. Their education in annual mandatory training was also not completed to include the following; Preventing and reporting abuse/neglect and exploitation. Dementia care and management. Infection Control. Resident rights. Person Centered Care. Communication. Skin and wound Care. Medication management. Pain management. Identification of change in condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cultural competency. Care of the cognitively impaired resident. Implementation of care plans. On 9-20-22 Director of Human Resources (Employee X) stated the employee training records were computer-based Relias training conducted in the facility. Employee X utilized her computer to facilitate the review, and provided copies to the Administrator to forward to the surveyors. The Director of Human Resources was asked who was responsible for clinical staff training, and she stated that it was the nursing departments' responsibility to ensure that the required annual performance reviews and subsequent training was completed. On 9-20-22 the Administrator, and the Director of Nursing (DON) were informed of the findings. When asked about the nursing departments' responsibility to ensure that nursing staff received the required performance reviews and training, the DON stated, I can't tell you about all of the required training. Staff are required to complete it online. I can follow-up with the Completion Report printed from Relias. On 9-20-22 at the end of day debrief the Administrator and DON stated that all of the staff performance reviews and education records they had were given to the survey team. No further information was provided by the facility at the time of exit on 9-22-22 at 4:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 31199 Based on observation, staff interview, and facility documentation review, the facility staff failed to post the required correct daily nursing staffing information which was visible to Residents, staff, and visitors, on four of four nursing units. The findings included: On 9-12-22 at approximately 11:30 AM, during initial tour of the building the daily staffing posting information was not correct, nor visibly posted. The posting continued to be incorrect on the second day of survey, 9-13-22. The posting simply had the name of staff members, and their arrival time. The posting was in a small back alcove with a desk behind the nursing station used for nurse and physician documentation and storage of documents. The posting was in the back of the alcove, not visible to anyone other than staff. On 9-13-22, the Director of Nursing (DON) was interviewed. The DON stated she would correct it immediately. On 9-13-22, during an end of day debrief with the facility Administrator and DON, they were made aware of the above findings. No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 31199 Based on staff interview and facility documentation review, the facility staff failed to ensure that required knowledge of, appropriate training for, and competencies were completed to care for residents with mental, psychological, and psycosocial disorders for 6 of 6 nursing staff members including, Registered Nurses (RN), Certified Nursing Aides (CNA), and Licensed Practical Nurses (LPN). The survey sample of 6 consisted of: (RN/DON), (CNA B), (CNA C), (CNA F), (LPN F), and (LPN G). The Findings included: The Facility failed to complete required initial, and annual, competency training, and evaluations. On 9-14-22 a review was requested for employee education/training and competency evaluations. The facility Administrator was asked for employee records for the 6 staff members. Each day from 9-14-22 through 9-18-22 the employee records were requested, and surveyors were told by the Administrator oh yes, I have them on my desk, I will send them to your email. On 9-19-22 education records and evaluation information was received. There were 4 of the 6 included and a call was placed to the Administrator to ask for the other 2 missing documents. The Administrator stated We can find nothing for those employees. The 4 that were received stated on the email from the Administrator the following; CNA (C) (name) does not have an annual eval on file, CNA (B) (name) has none, DON (name) has none, and LPN (F) (name) we only have termination. No mention was given for the other 2 staff LPN (G), and CNA (F) which were never received. The documents were reviewed and revealed that for all 6 staff members no annual evaluations nor competancy evaluations had been completed in the past year. In review of the education records received, only 3 staff members had education records. For the 3 employees who did have education records (DON), CNA (B) and CNA (C) none of them had received education in mandatory training to include the following; Dementia care and management. Respecting resident rights. Communication and interpersonal skills. Promoting residents independence. Caring for the residents enviroment. Mental health and social service needs. Care of the cognitively impaired resident. The DON had received training in behavioral health 1-31-22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9-20-22 Director of Human Resources (Employee X) stated the employee training records were computer-based Relias training conducted in the facility. Employee X utilized her computer to facilitate the review, and provided copies to the Administrator to forward to the surveyors. The Director of Human Resources was asked who was responsible for clinical staff training, and she stated that it was the nursing departments' responsibility to ensure that the required training was completed. On 9-20-22 the Administrator, and the Director of Nursing (DON) were informed of the findings. When asked about the nursing departments' responsibility to ensure that nursing staff received the required training, the DON stated, I can't tell you about all of the required training. Staff are required to complete it online. I can follow-up with the Completion Report printed from Relias. During the course of the 2 week survey deficient practice was levied at Immediate Jeopardy (IJ), and harm, in the area of abuse/neglect and exploitation, and in not providing rebabilitative services. It was also found that accident hazards existed for a demented resident, an unsafe discharge was performed for a dependant resident, quality of life was deficient, quality of care was levied at harm in 3 areas to include pressure sores and range of motion, significant medication errors were found, and notices for advocacy agencies were not posted for resident use. Residents recounted allegations of fear and retaliation during the entire survey, and facility known resident allegations of abuse had gone unreported and uninvestigated by the facility, and logged in a grievance file. The lack of training for staff competency may have contributed to these outcomes. On 9-20-22 at the end of day debrief the Administrator and DON stated that all of the staff education records they had were given to the survey team. No further information was provided by the facility at the time of exit on 9-22-22 at 4:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40452 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide comprehensive behavioral health services for one Resident (Resident #68) in a sample of 60 Residents. The findings included: Resident #68 was not receiving supportive therapy as recommended by the Mental Health Nurse Practitioner. Resident #68's clinical record was reviewed. According to Resident #68's quarterly Minimum Data Set with an Assessment Reference Date of 08/02/2022, Resident #68's medical diagnoses included but were not limited to Bipolar disorder. A nurse's note dated 06/01/2022 at 4:53 P.M. documented, Note Text: Writer was called to resident [#68] room by activity staff that the resident pushed his roommate's [Resident #70] face. Immediately writer went to the resident's room and the activity staff said she came to the resident's room to do an assessment on the resident's roommate at about 10:20 am. While the activity staff was conducting her UDA assessment on the resident's roommate who was lying on his bed, the activity staff asked the roommate about the resident, meanwhile, the resident was in the bathroom and he heard the activity staff asking about him. The resident's roommate then said to the activity staff Resident was in the bathroom and he's been there for too long. The resident while in the bathroom came out of the bathroom and started saying he is tired of his roommate and rushed toward roommate and pushed his face. The activity staff tried to stop him and resident rushed to the roommate who was lying on the bed and pushed his face. The resident was accompanied out of the room by the nurse. Head to toe assessment done on the resident's roommate and upon assessment, no bruises, no swelling, no skin tear, no discoloration, no injury, no s/s [signs/symptoms] of trauma noted. The resident also was assessed and no s/s of trauma noted and denies pain. The resident was immediately moved to another room and was separated from the roommate. The resident was asked why he pushed the roommate's face and the resident said 'I am tired of my roommate talking about me.' Resident was calmed at this time and was educated not to put his hand on any resident. Resident [#68] with history and diagnoses of Behavioral with major depressive disorder, bipolar disorder, yelling, complaining and using abusive language. MD [medical doctor] and RP [responsible party] made aware, new ordered [sic] for psych consult and evaluation. 911 was called spoke with officer [name], case number [number] Resident was separated and room changed to another wing on same unit. Resident is been monitored closely for any further behavior. The social worker was called and also spoke with the resident regarding his behavior. The resident remain calmed [sic] and in his new [sic] adjusting well with no complaints at this time. Resident was moved with all his belongings and the resident checked and made sure all his belongings were moved. We will continue with the plan of care. The facility staff provided a copy of three Resident-to-Resident Facility-Reported Incidents (FRI) involving Resident #68 and his roommates: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	FRI #1) Incident date 09/13/2020 with Resident #322. According to the incident description, there was a loud exchange of words heard by staff between Resident #68 and Resident #322 about whether or not to close the room door resulting in Resident #68 hitting Resident #322 on the back of his head. According to the 5-day follow-up report dated 09/17/2020, an excerpt documented, Education was provided to each resident about respecting other individuals' space and no physical contact without consent from the other individual. FRI #2) Incident date 08/13/2021 with Resident #321. According to the incident description, staff heard Resident #321 shouting that Resident #68 had hit him. Resident #321 was then treated for injury to eye and moved to room on adjacent hall. There were no supporting investigation documents such as written statements from staff, other potential witnesses, or interviews with other Residents. According to the FRI Investigation Summary under the header Summary of Investigation, an excerpt documented, Resident [#68] reported that he went to assist Resident [#321] who was eating from his wheelchair and had some food particles on his shirt. When he bent down to assist him, [Resident #321] hit him in the face, at which time he struck [Resident #321] in the face. The Summary also documented that Resident #321 had significantly impaired vision secondary to glaucoma. The Summary did not include Resident #321's version of events. According to a nurse's note in Resident #321's clinical record dated 08/13/2021 at 2:45 P.M., an excerpt documented, The resident stated, 'My roommate [Resident #68] came too close to my face and I punch him in his face and he also punch me in my face.' FRI #3) Incident date 06/01/2022 with Resident #70. An excerpt of an Activity staff member handwritten statement documented, I went into [room number] to see [Resident #68]. I asked [Resident #70] who was in (Bed A) where is [Resident #68] and [Resident #70] stated that he was in the bathroom-he always in the bathroom. I asked [Resident #68] how long will he be in the bathroom so [Resident #68] came flying out of the bathroom and rushed toward [Resident #70] saying I'm sick and tired of him. I tried to hold [Resident #68] back and he pushed me out of the way and put his hands in [Resident #70]'s face and then pushed his face and [Resident #70]'s head went to the edge of the bed. An excerpt of the Follow-Up Report written by the Director of Nursing dated 06/03/2022 under the section entitled Conclusion documented the following excerpt pertaining to Resident #68: behavior problems of being verbally abusive to staff and other residents, and he is receiving treatment to manage his health conditions. Resident has also been seen by the psychiatric NP [nurse practitioner] related to this behavior problems [sic]. Staffs [sic] will continue to monitor him closely, assist with care as needed, assess for pain, skin and will report any abnormal findings or behavior symptoms to the MD/NP. On 09/15/2022 at 5:30 P.M., the Ombudsman reported to the survey team that she heard Resident #68 verbally abuse his roommate with threat of physical harm at approximately 5:10 P.M. on 09/15/2022. On 09/15/2022 at 6:15 P.M., the Administrator, the Director of Nursing, and the Social Worker were notified of the Ombudsman's observation and the Administrator stated he had not been notified of the incident. When asked about Resident #68's altercations with roommates, the Social Worker stated the first altercation was with (Resident #321) and afterwards, Resident #68 was moved into a room with (Resident #77). The Social Worker then stated that staff started to see that they were not compatible and proactively moved (Resident #68) into a room with (Resident #70). The social worker stated that there was an altercation between Resident #68 and Resident #70 so Resident #68 was then moved into a room with (Resident #63).When asked how the facility staff determines which Resident would be a compatible roommate with (Resident #68), the social worker stated that (Resident #68) prefers to have a bathroom to himself so they opted to pair him with a roommate that is non-ambulatory and does not use the bathroom. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In Resident #68's electronic health record under the Miscellaneous tab, there were 4 scanned documents pertaining to mental health evaluations by mental health providers from one mental health company. There were three visits in 2020. One visit dated 09/16/2020 (following FRI #1) written by Employee S, a Mental Health Nurse Practitioner (MH-NP), under the header Chief Complaint documented, Staff reports patients had a physical altercations [sic] with former roommate. Request follow up to assess mood. Under the header Recommendations an excerpt documented, Will continue to provide supportive therapy to improve mood and physiological well-being. There was not another visit from the MH-NP until 06/02/2022 following another altercation between Resident #68 and his roommate 06/01/2022. On 09/20/2022 at 3:52 P.M., Employee S, MH-NP, was interviewed via telephone. When asked about Resident #68, the MH-NP explained that she saw Resident #68 back in June 2022 and again recently on 09/16/2022. The MH-NP stated that Resident #68 wants to have his own way with certain things; he wants to be in a room by himself so he picks fights because he knows they will remove the roommate. The MH-NP stated that there is an awareness of what he does and it doesn't fit behavior for medication; it's not fair to manage his condition with medications but more talking with him and how his behavior impacts others and his behavior may be traumatic to others. The MH-NP explained that she manages Resident #68's bipolar disorder with medication and does not see him routinely. The MH-NP stated that she primarily does medication management and a talk therapist used to go to the facility as well but was unsure if the talk therapist worked with Resident #68. The MH-NP stated that back in 2020, she told an in-house therapist that Resident #68 would benefit from talk therapy. In the course of the interview, the MH-NP Company Manager joined the call. When asked about referrals for talk therapy, the Manager stated that they currently don't have a provider but are actively recruiting for one. The Manager also stated that the facility is aware we don't have a provider. On 09/22/2022 at 12:07 P.M., the Social Worker, Employee E, was interviewed. When asked about mental health services offered at the facility, the Social Worker stated that residents with mental illness or any resident that requests mental health services can let the nurse know, and the nurse will get an order for mental health services. The Social Worker stated that she herself utilizes a tool to identify if someone is depressed. The Social Worker stated that if behavior modification is needed, the resident could be referred to a psychologist onsite named [Employee S] who does talk therapy. When informed Employee S is a nurse practitioner that primarily does medication management, the Social Worker stated she didn't know that. The Social Worker stated that she hasn't asked Resident #68 if he would like supportive therapy because, to be honest, he doesn't want to be here and I'm trying to find him placement somewhere else. When asked what is being done to help Resident #68 with his mental health, the Social Worker stated, Medications, that's it. The Social Worker stated that Resident #68 would definitely benefit from one-on-one therapy sessions and stated I will get that ball rolling. The facility staff provided a copy of their policy entitled, Social Services. In Section 7, it was documented, The social services staff shall be responsible for making referrals to community social service agencies, should a resident require a service that cannot readily be provided by the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40026 Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to provide routine and emergency drugs to meet the needs of residents and failed to provide safekeeping of hard scripts for controlled drugs, for 2 Residents (Resident #86 and 68) in a survey sample of 60 Residents. The findings included: 1. For Resident #86 the facility staff failed to obtain ordered narcotic pain medication, causing the Resident to wait 3 days for ordered pain medicine. On 9/12/22 a review of Resident #86's clinical record revealed she had pain medication ordered as follows: Oxycodone 5 mg [milligrams] / 5 ml [milliliters 5 ml via PEG-Tube every 8 hours for pain beginning on admission 8/13/22. The following are excerpts from Resident #86's nursing progress notes: 9/2/22 3:09 PM-eMar -Medication Administration Note Note Text: oxycodone HCl Oral Solution 5 MG/5ML Give 5 ml via PEG-Tube every 8 hours for pain Pharmacy stated resident needs script . 9/8/2022 4:24 PM eMar -Medication Administration Note Note Text: oxycodone HCl Oral Solution 5 MG/5ML Give 5 ml via PEG-Tube every 8 hours for pain. Awaiting for pharmacy . 9/8/2022 10:00 PM - 2 -eMar -Medication Administration Note Note Text: oxycodone HCl Oral Solution 5 MG/5ML Give 5 ml via PEG-Tube every 8 hours for pain Awaiting pharmacy delivery . 9/9/2022 10:04 PM eMar -Medication Administration Note Note Text: oxycodone HCl Oral Solution 5 MG/5ML Give 5 ml via PEG-Tube every 8 hours for pain awaiting pharmacy delivery. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the MAR (Medication Administration Record) revealed that Resident #88 did not receive her ordered narcotic pain medication until 09/12/22, however the Resident was receiving her PRN Tylenol and her muscle relaxers during that period of time. The following excerpts are from the physician progress notes: 9/1/2022 13:39 Nurse Practitioner/PA Progress Note (Narrative) Note Text: [Physician practice name redacted] Medical Progress Note CC: asked by nursing to see for back pain . 9/13/2022 2:40 PM Nurse Practitioner/PA Progress Note (Narrative) Note Text: Medical Progress Note CC: asked by nursing to see for back pain Chronic Back Pain, Lumbar degenerative disc disease was admitted to [Hospital name redacted] 8/10-8/12/22 due to back spasm pain along with wanting a different rehab other than [Rehab name redacted] in Arlington where pt. was just at. Pt has Recent ALS diagnosis . Back pain- improves with oxycodone use but needs sooner. On 9/12/22 at approximately 3:00 PM an interview was conducted with LPN G who was asked what the procedure was for reordering medication. She stated that the orders would be sent to the pharmacy and if it would arrive on the next shipment. When asked if you needed a medication sooner what could you do she stated we could get it from the stat box. When asked if narcotics are located there she said they were. On 9/12/22 at approximately 4:00 PM an interview was conducted with the DON and she was asked the process for obtaining medications if the Resident had a new order and needed them immediately. She stated the facility could use the stat box or the backup pharmacy. When asked what the expectation is if a Resident has a G Tube and the medication ordered is not available in the stat box in liquid form. She stated they are expected to call the physician and see if a substitute would be available or if they wanted to try a different medication or get an order to crush a pill and dissolve it in water to administer. At on 9/15/22 at during the end of day conference the Administrator was made aware of the concerns and no further information was provided. 41449 2. For Resident #68, the facility staff failed to provide safekeeping of hard scripts for controlled drugs, to prevent drug diversion. On 9/13/22 at 8:46 AM, during an interview with the facility Administrator and while he was looking for a document, it was observed at the nursing station on the first floor a drawer would not close and was open. An original hard script for Hydrocodone-Acetaminophen 5 mg-325 mg tablets, with a quantity of 90 tablets to be filled, was noted. The prescription was dated 2/15/22, and had not been voided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/13/22, the unit manager/RN C approached the nursing station and was shown the prescription. RN C said, It is supposed to be put in an envelope and sent to the pharmacy. When asked what the risk of having prescriptions that were not voided, RN C said, There are a lot of risks, someone can take this and go get the prescription filled, and it is not safe. On 9/13/22 at 10:12 AM, RN C was observed at the first floor nursing station going through all of the drawers at the station and stated, I am working my plan of correction. RN C acknowledged she had found quite a few other original prescriptions that had been left at the desk and were not voided, which were available to be filled. On 9/15/22 at 12:20 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked to explain the process when the doctor writes and provides a prescription for a narcotic medication. The DON said, They fax it to the pharmacy. The DON was unable to explain the steps following that and said, I will get the policy for you. The facility policy regarding the process for narcotic prescription handling was requested. The facility provided a policy titled, Storage of Medications. The process for handling narcotic prescriptions was not addressed in this policy. On 9/13/22, during an end of day meeting the Facility Administrator and DON were made aware of the findings. No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, facility record review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure 1 Resident was free from unnecessary medications (Resident #101) in a survey sample of 33 Residents. The findings included: Resident #101 received Atenolol anti-hypertensive medication, Dexamethasone anti-inflammatory steroid medication, and Metronidazole antibiotic medication against physician ordered parameters. Resident #101 was admitted to the facility on [DATE]. Diagnoses included but were not limited to; hypertension. Resident #101's most recent Minimum Data Set assessment (a federal assessment protocol) was a discharge assessment dated [DATE]. Review of the physician's orders and Medication Administration Record (MAR), in the clinical record, revealed the following; 1. Ordered 7-10-22 - Atenolol for high blood pressure - 100 MG (milligrams) in the morning, hold for systolic blood pressure (SBP) less than 110. The Atenolol unnecessary medication was given on the following days; On 7-22-22 with an SBP of 105, On 8-10-22 SBP of 104, On 8-14-22 SBP of 100, On 8-28-22 SBP of 102, On 10-29-22 SBP of 101. 2. Ordered 7-11-22 - Dexamethasone for diverticulitis inflammation - 1 MG in the morning for 3 days. However, the Dexamethasone medication was given for 7 days. 3. Ordered 7-10-22 - Metronidazole antibiotic for diverticulosis - 500 MG once per day, and the next day on 7-11-22 the order changed to - Metronidazole antibiotic for diverticulitis - 500 MG every 8 hours (3 times per day) for 7 days. There were 2 extra does of Metronidazole given. On 1-10-23 an interview was conducted with LPN D who stated about the Atenolol medications being administered unnecessarily, she stated we don't want to give Antihypertensives outside of parameters because we don't want them to bottom out. (become Hypotension), and antibiotics and steroids should only be given for a short time and per orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy for Medication Administration was reviewed, and documented that medications must be given according to the physician's orders. On 1-10-23 at 12:00 p.m., the Administrator and Director of Nursing (DON) were made aware of the findings. At the time of exit the DON stated there was no further information available to submit to surveyors. Complaint Deficiency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 40026 Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free of significant medication errors for 2 Residents (#'s 88, & 86) in a survey sample of 60 Residents. The findings included 1. For Resident #88 the facility staff failed to ensure the correct administration of the anticoagulant Lovenox (generic name Enoxaparin Sodium) was ordered and given as directed by the physician. On 9/13/22 at approximately 2:00 PM an interview was conducted with Resident # 88 who stated that he has been getting the wrong dose of medication for his blood clots and just found out this week it was the wrong dose. He stated his doctor that he sees for his blood clot had put him on shots in the stomach and the medication should have been 100 mg every 12 hrs. But that he was only getting 80 mg. A review of the clinical record revealed that Resident #88 had physician's orders that read: 8/11/22 8:15 PM Enoxaparin Sodium Injection Solution Prefilled Syringe 100 MG/ML (Enoxaparin Sodium) Inject 1 ml subcutaneously every morning and at bedtime for clotting A review of the MAR (Medication Administration Record) for the month of August 2022 revealed the record was signed off as being given as follows: Enoxaparin Sodium Injection Solution Prefilled Syringe 100 MG/ML (Enoxaparin Sodium) Inject 1 ml subcutaneously every morning and at bedtime for clotting -D/C Date 08/12/2022 2:13 PM . (**Please note the Resident received the correct dose for 8/11/22 and 8/12/22 the order was then discontinued and the following order was initiated.) On 8/12/22 9:00 PM the order was changed to: Medication: Enoxaparin Sodium Injection Solution Prefilled Syringe 80 MG/0.8 Generic: Enoxaparin Sodium Medication Class: ANTICOAGULANTS Enoxaparin Sodium Injection Solution Prefilled Syringe 80 MG/0.8 ML (Enoxaparin Sodium) Inject 100 mg/ml subcutaneously every 12 hours for PE/DVT until 08/16/2022 12:02 for 8 administrations (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/14/22 at 9:30 AM an interview was conducted with LPN C who was asked how she administers medications and she stated that she looks at the order and the medication available in the drawer making sure the order and the medication are the same before administering the medication. When asked about the dangers of giving the wrong dose of an Anticoagulant she stated that if a Resident gets too much of it he or she can bleed out, if he or she gets too little they risk a blood clot. On 9/14/22 at approximately 3:00 PM an interview was conducted with the DON who was asked if the nurses should be checking the dosage with the medication and comparing to ensure proper dosage. She stated that this is the expectation for all nurses to perform the Rights of medication administration. When she was asked about the Lovenox order for Resident #88 she stated was aware that this happened but she insisted that the Resident was never given in the wrong dose. She stated that the medication was ordered and received by the pharmacy in the 100 mg / 1 ml prefilled syringes. When asked why the order was changed from the original (correct) ordered dosage to an incorrect dose she stated that the nurse who put the order in the system hit the wrong line on the drop down box and ordered 80 mg/0.8 ml instead of the 100 ml / ml prefilled syringes. When asked if anyone clarified the order to see what the correct order should be when comparing the dose ordered with the medication on hand she stated they did not. ON 9/15/22 during the end of day meeting the Administrator was made aware of the concern and no further information was provided. 2. For Resident # 86 the facility staff failed to administer Oxycodone (a narcotic pain medication) as prescribed by physician. On 9/20/22 at approximately 3:00 PM Surveyor D observed a Resident orders for Oxycodone. The orders read as follows: Oxycodone HCl Oral Solution 5 MG/5 ML (Oxycodone HCl) Give 5 milliliter via PEG-Tube every 6 hours for pain Start Date 9/13/22 6:00 PM - D/C Date 09/18/2022 11:27 AM . [Please note this is a ROUTINE not PRN] . Oxycodone HCl Oral Solution 5 MG/5 ML (Oxycodone HCl) Give 5 milliliter via PEG-Tube every 6 hours as needed for pain Start Date 9/13/22 -D/C Date 09/18/2022 11:27 AM Oxycodone HCl Oral Solution 5 MG/5 ML (Oxycodone HCl) Give 5 ml via G-Tube every 6 hours as needed for pain Date Started 9/13/22 - [Active Order] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Oxycodone HCl Oral Solution 5 MG/5 ML (Oxycodone HCl) Give 7.5 ml via G-Tube every 6 hours for pain, Start Date 9/18/22 12:00 PM [Active Order] [Please note this is a ROUTINE order not PRN]. As per the MAR and physicians orders the Resident had duplicate PRN Oxycodone orders. In the medication cart Resident #86 had 2 bottles of Oxycodone labeled as follows: 9/19/22 - Oxycodone 5 MG/5 ML Give 5 milliliter via Peg tube every 6 hours for pain and give 5 milliners via peg tube every 6 hours as needed for pain. 9/20/22 - Oxycodone 5 MG/5 ML Give 7.5 ML per peg tube every 6 hours for pain. A review of the narcotic sheets revealed that the Resident received the correct dosages of medications however the nursing staff dispensed the medications from incorrectly labeled bottles. [They did not follow label instructions thus they did not compare the label to order.] 9/19/22 - Oxycodone 5 MG/5 ML Give 5 milliliter via Peg tube every 6 hours for pain and give 5 milliners via peg tube every 6 hours as needed for pain 9/18/22 - 5 ml at 2100 PM 9/19/22 - 7.5 ml at 12:30 AM 9/19/22 - 7.5 ml at 6:00 AM 9/19/22 - 7.5 ml at 12:15 PM 9/19/22 - 7.5 ml at 6:00 PM 9/20/22 - 7.5 ml at 12:00 AM 9/20/22 - 7.5 ml at 6:00 AM 9/20/22 - 5 ml at 9:00 AM 9/21/22 - 5 ml at 9:00 AM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/20/22 - Oxycodone 5 MG/5 ML Give 7.5 ML per peg tube every 6 hours for pain. 9/20/22 - 7.5 ml [no time administered is recorded] 9/20/22 - 7.5 ml at 6:00 PM 9/21/22 - 7.5 ml at 12:00 AM 9/21/22 - 7.5 ml at 6:00 AM 9/21/22 - 7.5 ml at 1:20 PM On 9/21/22 an interview was held with the DON who was made aware of the medication label being incorrect and the Medication being administered in doses that were not indicated on the label of each bottle. When asked what the expectation of the nurses are when giving medications she stated they are expected to read the order as well as the label on the prescription bottle. A review of the facility Policy #39 entitled Medication Labels read: Procedures . 6. if the physician's directions for use change or the label is inaccurate, the nurse may place a Change of Order-Check Chart label on the container indicating there is a change in directions for use, taking care not to cover important label information. a. When such a label appears on the container, the medication nurse checks the resident's medication administration record (MAR) or the physicians order for current information. b. The pharmacy is informed prior to the next refill of the prescription so the new container will contain an accurate label and quantity. No Change of Order - Check Chart label was found on either bottle. On 9/21/22 during the end of day meeting the Administrator was made aware and no further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to properly store Drugs and Biological's for 2 of the facility's 4 medication carts. The Findings Included: On 9/21/22 while completing the medication administration facility tasks Surveyor D made the following observations: At 2:50 PM on the Colonial Hall cart 1, observed artificial tears eye drops labeled with the Resident name and room number as well as the opened date on the box only, LPN L was asked was asked what the process was for labeling medications and she stated that the name, and date opened should be on the box on the bottle as well. When asked why she stated that if it's not labeled correctly the medication could get mixed up with someone else's. At 2:53 PM on the Washington Hall cart 1, observed artificial tears eye drops labeled with the Resident name and room number as well as the opened date on the box only, LPN M was asked was asked what the process was for labeling medications and she stated that the name and room number, and date opened should be on the box and the bottle. When asked why she stated that if it's not labeled correctly the medication could get mixed up with someone else's. Also on the Washington Hall cart 1, was a sticky bottle of lactulose with no date opened on the bottle. The prescription label shows the date it was sent to facility as 8/22/22. LPN M was asked how long the medication is good for once it is opened and she stated 30 days. Then said we have no way of knowing what date it was opened I will have to check in PCC (electronic health record.) When asked what is the correct way to label the medication she stated the date you open the med should be written on the bottle with the Residents name. At 3:30 PM on the Independence Hall cart 1 observer a Budesonide inhaler labeled the Resident name and room number only written on the box. The inhaler itself was tabled. RN D was asked what the process was for labeling medications and she stated that the name and room number should be on the inhaler and the box and the box should have the date it was opened also written on it. When asked why she stated that if it's not labeled correctly the inhaler could get mixed up with someone else's inhaler. A review of the facility policy for medications labeling and storage read as follows: Policy #39 entitled Medication Labels Procedures (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Labels are permanently affixed to the outside of the prescription container. No medicine is accepted with the label inserted into a vial. If a label does not fit on the product. e.g . Eye drops, the label may be affixed to the outside container or carton, but the Resident's name must be maintained directly on the actual product . 5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. a. The nurse place a date opened sticker on the medication and enter the date opened. b. If the vial or container is found without a date opened the date opened will automatically default to the date dispensed and the expiration date will be calculated accordingly. On 9/21/22 during the end of day meeting the Administrator was made aware and no further information was provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed ensure the nutritional needs and special diet orders 1 Resident (#86) in a survey sample of 60 Residents. The findings included: For Resident #86 the facility staff failed to obtain orders for the tube feeding formula (i.e. Jevity 1.2); the facility staff only received orders for the tube feeding flushes on admission. On 9/12/22 at approximately 4:00 PM the following observation was made: Tube feed Jevity 1.2 was hanging and infusing via enteral pump at 45 ml per hour. The 60 ml piston syringe was not dated and the tube feeding was not dated nor was the tubing. On 9/13/22 a review of the clinical record revealed that Resident # 86 was admitted on [DATE] with diagnoses that included dysphasia, failure to thrive, and a peg tube had been inserted at the hospital. Per signed admission orders the Resident had orders for flushing the G Tube both PRN (as needed) and routine flushing before and after feeding and medication administration, however they had neglected to secure orders for the tube feeding itself. On 9/13/22 at approximately 5:00 PM an interview was conducted with LPN B who stated that the Resident came into the facility with a g-tube and Jevity 1.2 infusing at 45/ml per hour on the enteral pump. She stated that they continued to hang Jevity at that rate until they got new orders from the Speech Therapist or Dietician. She stated she gets pleasure trays now like ice cream & ginger ale. On 9/14/22 at approximately 4:30 PM Employee O (dietary staff) was asked to print out the tray ticket for Resident #86. Employee O gave this surveyor a ticket that read: [Resident #86 name] Reg / Full Liquids . Chicken Asparagus, potato, bread and ice cream. When asked what that meant Reg/ Full liquids Employee O stated it means she gets regular tray with full liquids not thickened and no fluid restriction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/15/22 at approximately 2:30 PM an interview was conducted with the Speech Therapist who stated that she has been working with Resident #86 since admission. When asked about the tray ticket she stated that this is something she has been dealing with for a long time. In the beginning Resident #86 was supposed to be NPO no tray at all until she had done her evaluations and trials with her. She said the Resident can now have soups and broths that are not chunky, she can have ice cream with supervision. She stated she will not eat much at all but they still should not be giving her regular trays. Resident #86's signed admission orders for dietary read: NPO (Nothing by Mouth), NPO Texture, NPO Consistency dated 8/13/22'. The physician put in enteral Feed orders that read: Enteral Feed Order As needed flush. Flush with at least 30 ml. of water before and after each med pass and feeding Enteral Feed Order Every 8 hours as needed for Tube Flush. Flush tube with at least 5 ml. water with each medication. On 8/25/22 Admission Nutrition Assessment was completed by the Dietician and read as follows: Full liquid diet Jevity 1.5 @ 45mL/hr . RD recs: -initiate free water flush 100mL Q 6hrs for hydration -clarify tube feeding order to say Jevity @ 45mL/hr. x 20 hours. A review of the weights revealed that Resident # 86 lost 2 lbs. from 8/12/22 - 9/7/22. Her recorded weights were as follows: 9/7/2022 - 112.8 Lbs. 8/30/2022 - 113.0 Lbs. 8/12/2022 - 114.8 Lbs. On 9/20/22 during the end of day meeting the Administrator and the DON were made aware of the concerns and no further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 41449 Based on observations, Resident/family interview, staff interview, clinical record review, facility documentation review and in the course of a complaint investigation, the facility staff failed to provide specialized rehabilitative services to prevent the functional decline for two Residents (Resident #14 and #68), resulting in harm for Resident #14, in a survey sample of 60 Residents. The findings included: 1. For Resident #14, who developed a hand/wrist contracture while a Resident of the facility, the facility staff failed to provide specialized rehabilitative services as ordered by the physician, to prevent the worsening of the contracture for a period of two months resulting in harm. On 09/12/22 at 02:49 PM, Resident #14 was visited in her room and a family member was at the bedside. A Resident and family interview were conducted. Resident #14's family member said he is very concerned about the Resident's left hand, she is no longer able to use it and when you touch it she has pain. The family member went on to say that they have talked to various staff, including but not limited to nursing and the social worker to request therapy services for several months and still nothing has been done. During the above interview, Surveyor B observed Resident #14's left hand and noted that her fingers appeared to be contracted in a closed position, her wrist appeared to have some limited movement as well. When asked if she (Resident #14) could open her hand she was not able to do so independently. Resident #14's finger nails appeared very long and were making contact with her palm which was in a closed fist position. There was no brace, wash cloth or any other device observed in her hand. Review of the clinical record for Resident #14 revealed the following: a. A physician order dated 7/13/22, that read, OT [occupational therapy] evaluation for splint for left hand contracture of fingers. A progress note written by the provider the same day read, .Assessment / Plan 1. Contracture of multiple joints- particularly left hand with apparent pain with movement and when try to examine it but seems comfortable when left alone 2. degenerative joint disease of hand - Left -has rings on 2-4 fingers not able to be removed due to osteoarthritis of pip, neurovascular intact distally no sign acute synovitis -discussed with son this evening will have OT see for possible splint to minimize movement may help with pain for care and handling of patient . b. A physician progress note dated 8/23/22, that read, .Follow-up: Contracture of multiple joints . Musculoskeletal System: Hand: no erythema or warmth and limited both active and passive extension left finger(s); able to move arm to examine and hand but does draw away when attempt to open fingers, rings on fingers but distal neurovascular intact. Musculoskeletal System contracture of extremities .Assessment / Plan: 1. Contracture of joint of left hand - no erythema, no warmth does pull away when attempts to move fingers - have asked OT to see patient for contracture cushion . c. There was no evidence within the clinical record that therapy services had been initiated as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Actual harm Residents Affected - Few	d. The MDS [minimum data set - an assessment tool] conducted 3/6/22, which was coded as an annual assessment was reviewed. This assessment was coded in section G0400. Functional Limitation in Range of Motion, question G0400 A: Upper extremity (shoulder, elbow, wrist, hand): no impairment. e. The MDS [minimum data set/an assessment tool] conducted 6/24/22, which was coded as a quarterly assessment was reviewed. This assessment was coded in section G0400. Functional Limitation in Range of Motion, question G0400 A: Upper extremity (shoulder, elbow, wrist, hand): no impairment. f. Resident #14's care plan doesn't identify or address the hand contracture and therefore no interventions are in place to prevent further decline. On 9/15/22 at 9:15 AM, an interview was conducted with Employee N - the rehab director. Employee N accessed the therapy records and was asked to identify if and when Resident #14 had received therapy services. Employee N stated that she had not previously been on the therapy caseload but when they screened her two weeks ago due to an upcoming MDS [minimum data set assessment] and a therapy referral being entered on 9/1/22, they determined she needed services and were planning to start therapy today or tomorrow. Employee N reviewed the physician orders and stated he was not aware of the physician order entered on 7/13/22, he said, This is the first time I'm seeing the order from July. Employee N stated, If the doctor writes and enters an order I don't get a notification. Nursing has to go in and enter a therapy referral for us to get a trigger. Employee N confirmed that Resident #14 had been screened for therapy services 5/24/22, and was at baseline with no contractures identified at that time. On 9/15/22, an interview was conducted with the facility social worker/Employee E. Employee E confirmed that she recalled Resident #14's family talking with her about and requesting therapy services and she had notified the rehab director. Employee E provided the survey team with a copy of an email that she sent on 8/15/22, that read, [Resident #14's name redacted] have you assesd her for the hand - the son was asking . On 9/15/22, the facility Administration was asked to provide a timeline with regards to Resident #14's contracture development. The facility provided copies of admission assessments which revealed the contractures were not present upon her admission to the facility and were developed/acquired in-house. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Actual harm Residents Affected - Few	On 9/15/22 at 7:20 PM, the therapy director provided the survey team with a copy of the Occupational Therapy (OT) evaluation that was completed for Resident #14 on 9/15/22. It read, .Reason for Referral: Patient is a 88 y/o [year old] female referred to skilled OT evaluation for assessment and management of LUE [left upper extremity] flexor contractures at elbow, wrist and hand due to hx [history] of R [right] intracranial hemorrhage LUE [left upper extremity] ROM [range of motion]= Impaired (L wrist rests in 80 degrees flexion with ~30 degrees of passive extension from fixed position available. L D3 [left digit 3/finger] and 4 most severe with 90 degree contractures from MCP [Metacarpophalangeal joint/commonly known as knuckles] to DIP [Distal Interphalangeal Joint/bones at the tip of the fingers]. L thumb proximal phalange in fixed adducted position with hyperextension of IP joint, unable to form functional grasp. L D2 and D5 [left digit 2 and 5/ index and pinky fingers] are least affected with resting MCP flexion at 90 degrees and ability to extend 45 degrees from this position, distal segments flaccid and passively WFL [Within Functional Limits]. L elbow passively WFL, shoulder flexion PROM [passive range of motion] 0-120 degrees and AROM [active range of motion] 0-35 degrees; patient rests in elbow flexion (~70 degrees) and internal rotation . Resident #14 was admitted to the facility without contractures, and developed contractures at the facility. This constitutes harm for Resident #14. 40452 2. For Resident #68, the facility staff failed to provide physical therapy services as ordered by the physician. On 09/12/2022 at approximately 12:35 P.M., Resident #68 was interviewed. When asked about having any concerns about care at the facility, Resident #68 stated that he has not received physical therapy. On 09/13/2022, Resident #68's clinical record was reviewed. A physician's order dated 08/10/2021 documented, Physical therapy evaluate and treat for generalized weakness, bilateral lower extremity weakness. On 09/13/2022 at 10:45 A.M., the Director of Rehab was interviewed. When asked about dates of service for Resident #68, the Director of Rehab referred to Resident #68's electronic health record and stated that Resident #68 was admitted to the facility in 2019 and received therapy services in 2020. This surveyor observed the therapy electronic record that the only dates of service listed were 07/14/2020 through 09/16/2020. The Director of Rehab verified Resident #68 had not received therapy services since 2020. When asked about the process for receiving orders for therapy services, the Director of Rehab stated that if the physician writes an order for therapy, the therapy department does not get alerted to the order for therapy. The Director of Rehab explained that nursing would see the order and put a Nursing referral to therapy and Therapy Notification into the system which is located under the Assessment tab in the electronic health record. The Director of Rehab then stated that once that is done, it shows up on the dashboard. The Director of Rehab stated that he checks his dashboard daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to establish and maintain an effective infection prevention control program to prevent the development and spread of diseases and infections for 1 Resident (#88), and the facility as a whole. In addition, 8 facility staff on 4 of 4 units failed to maintain an effective infection prevention and control program. The findings included: 1. For Resident #88 the facility staff failed to ensure proper care and cleaning of Resident #88's suprapubic catheter. A review of the clinical record revealed that Resident #88 was brought to the hospital by his fiancee on 8/5/22 and was admitted with a diagnosis of Poly-Microbial (more than one bacteria) UTI (Urinary Tract Infection). The identified bacteria were: Providencia Stuartii. Enterococcus Fecalis Providencia, P. rettgeri and P. stuartii are the most common cause of catheter-associated urinary tract infections, especially in the elderly with long-term indwelling urinary catheters. While, both of these bacteria are normal when found in the gastrointestinal system, they are infection causing when found in the urinary tract.) Resident #88 was discharged to the facility on [DATE] with orders to continue IV antibiotics started in the hospital. On 9/12/22 at 12:00 PM and again on the morning of 9/13/22 Resident # 88 was observed with this suprapubic catheter collection bag hanging from the back of his wheel chair near the handle above his waist height. On 9/13/22 at approximately 10 AM an interview was conducted with Resident #88 and he was asked if it was usual practice for the staff to hang his collection bag for his catheter on the wheel chair handle and he stated that it was. On 9/12/22 at approximately 12:15 PM CNA E was asked if his bag was hanging correctly and she stated yes it has got to be up here so it doesn't hit the floor. On 9/13/22 the following notes were taken by Surveyor D in the Resident Council meeting. A review of the Resident counsel minutes for July 2022 revealed that Resident Counsel had been complaining about call bells not being answered timely and incontinence care not being provided timely. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #88 stated that call bell answer times are still an issue. He further elaborated that what the staff are doing is come by and shut light off and say they'll get your aide or say someone is coming but no one comes. If they do show up it takes a long time for them to come take care of your needs. Per the Social Worker the facility conducted in-services about call bells, and incontinence care however she did not know the dates. A review of the facility documentation revealed that on 8/27/22 a, Training Sign-In Log was signed by 17 staff members both CNA's and Nurses, on the topics of timely answering of call bells, Perineal Care and ADL care. On 9/13/22 during the end of day meeting a request was made for the facility's policy and procedure on Catheter Care. On 9/15/22 at 1:00 PM an interview was conducted with the DON who was asked if placing the catheter collection bag above the waist height was acceptable. She stated that it was not when asked why she stated that the urine could back flow into the bladder and cause infection. The DON was asked a second time to provide a policy on Catheter care. On 9/14/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 31199 2. Eight staff members on 4 units failed to appropriately wear PPE (personal protective equipment) in the facility during an outbreak of Covid-19. All staff were required to wear N-95 source control masks, and eye protection at all times in the facility. Staff were also required to use gowns and gloves when providing care to residents who had Covid-19, or who had been exposed during hospitalization , and were newly admitted into quarantine for 10 days. On 9-12-22 during entrance and initial tour of the facility, and continuing through 9-13-22 the following observations were made by Surveyors; 9-12-22 during initial tour Certified Nursing Assistant (CNA M) was observed wearing an N-95 with the bottom strap off and hanging loosely in front of the mask, and stated it was an accident. CNA (M), and Licensed Practical Nurse (LPN G) the unit manager, were working with Resident #320. They were asked if the Resident was on droplet/Covid-19 precautions and both stated no. LPN (G) then stated I will have to ask. Resident #320 was on droplet Covid-19 precautions. On 9-13-22 after day observations had been completed, surveyors returned to the facility to make evening observations at 9:15 p.m Upon entrance to the building, CNA (T) had no mask on, 2 staff members on the 100 hall had no mask or eye protection on, and hurried away upon seeing surveyors approach, CNA (G) was observed without a mask, and asked why, she responded so I can breathe, and the mask gives me a rash. CNA (G) called CNA (K) out of a resident room, and he exited the room of 2 residents without a mask or eye protection on. LPN (B) was standing in the hallway at the medication cart with the bottom strap of her mask off and no eye protection, then proceeded down the hall and into a resident room with no changes to her PPE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator was asked what the facility was currently requiring all staff to use for PPE in the facility and he stated that all staff are instructed to wear N-95 masks with face shields or goggles throughout the building. On 9-14-22 during the end of day debriefing the Administrator, and Director of Nursing were made aware of the concerns and no further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure staff are vaccinated for COVID-19 34894 Based on staff interview and facility documentation review, the facility staff failed to have an accurate system to track the immunization status, provide COVID-19 immunizations, and provide COVID-19 booster immunizations for two employees (Employee GG and CNA-X) in a survey sample of 6 employees reviewed. The findings included: On 9/12/2022, the facility staff provided the survey team with a copy of the staff vaccination matrix. On 9/13/2022 at 10:30 a.m., review of the matrix revealed five employees listed as not vaccinated. There were 19 employees listed as not Boosted. On 9/13/2022 at 2:45 p.m., an interview was conducted with the Infection Preventionist who stated all of the employees were fully vaccinated and that there were no employees with an exemption. When asked about the 5 employees listed as unvaccinated, the Infection Preventionist stated the Administrator must have scanned the wrong documents. She stated she updates the forms every day and that there were multiple copies. The Infection Preventionist stated she would send the correct copy of the vaccination matrix. She again stated none of the employees had an exemption. During the end of day debriefing on 9/13/2022, the Administrator, Director of Nursing and Regional Consultants were informed that the staff vaccination matrix/tracking system in use on the first day of survey was not complete and accurate. Review of the corrected copy of the vaccination matrix revealed there were no unvaccinated staff members listed on the matrix. There were 3 listed as not Boosted. CNA-X, had completed a primary COVID-19 vaccine series on 5/12/21 and 6/2/2021 but had not received a booster dose. Employee GG, had completed a primary COVID-19 vaccine series 9/7/2021 and second dose on 9/28/2021 but had not received a booster dose. On 9/21/2022, during the end of the day meeting, the facility Administrator, Regional Nurse Consultant, Regional Consultant for Infection Control and Director of Nursing again were informed that the staff vaccination matrix/tracking system in use on the first day of survey was not complete and accurate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/22/2022, the Infection Preventionist provided copies of the immunization cards as requested. An interview was conducted with the Infection Preventionist who confirmed the findings and stated, I do follow-up on whether or not a staff member gets a booster shot. I send an email and I discuss it at our meetings too. The Infection Preventionist stated there were employees who did not have booster doses. She stated she did provide education on the importance of the full vaccination series along with a booster. The Infection Preventionist stated she did not document the education she provided to the employees about the importance of booster dose. The CDC (Centers for Disease Control and Prevention) document titled, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated February 2, 2022, page 3, subtitle, Vaccinations, read, Remaining up to date with all recommended COVID-19 vaccine doses is critical to protect both staff and residents against SARS-CoV-2 infection. No additional information was received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41449 Based on observation, Resident interview, staff interview and facility documentation review, the facility staff failed to provide a functional bedside table for one Resident (Resident #35) in a survey sample of 60 Residents. The findings included: On 9/14/22 at 9:30 AM, Surveyor B visited Resident #35 in his room. Surveyor B observed the bedside table, which had 3 drawers. The top drawer had no handle and the second drawer the handle was broken and attached on only one side. Resident #35 was asked how he accesses items in the top drawer and he said he couldn't. On 9/14/22 at approximately 9:45 AM, an interview was conducted with Employee F, the Maintenance Director. Employee F described the process by which he is made aware of items needing repair as an electronic system that any employee is able to enter maintenance requests into. Employee F provided Surveyor B with a listing of maintenance work orders that had not been completed and Resident #35's bedside table was not noted on the list. Employee F accompanied Surveyor B to the room of Resident #35. Employee F made an observation of the bedside table and confirmed the above finding. Employee F said, he was not aware of this and would get this replaced right now. The facility policy regarding the upkeep of facility provided equipment and maintenance work orders was requested. The facility policy titled, Maintenance Work Request System was reviewed. This policy read, Policy: 1. to establish an effective means of requesting, coordinating and completing maintenance of a corrective nature. Procedure: 1. Corrective maintenance can be defined as those actions required to restore equipment, buildings and grounds to normal condition and operation. The following procedures are established to initiate and carry out an effective program and is considered a normal means for obtaining maintenance action On 9/14/22, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the above findings. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 31199 Based on staff interview, and facility documentation review, the facility staff failed to ensure that required training for Abuse/neglect, misappropriation, exploitation, dementia management, and abuse prevention were conducted for all 6 of the employees in the employee sample, (RN/DON), (CNA B), (CNA C), (CNA F), (LPN F), and (LPN G). The Findings included: The Facility failed to complete required abuse and dementia competency training, and evaluations. On 9-14-22 a review was requested for employee education/training and competency evaluations. The facility Administrator was asked for employee records for the 6 staff members. Each day from 9-14-22 through 9-18-22 the employee records were requested, and surveyors were told by the Administrator oh yes, I have them on my desk, I will send them to your email. On 9-19-22 education records and evaluation information was received. There were 4 of the 6 included and a call was placed to the Administrator to ask for the other 2 missing documents. The Administrator stated We can find nothing for those employees. The 4 that were received stated on the email from the Administrator the following; CNA (C) (name) does not have an annual eval on file, CNA (B) (name) has none, DON (name) has none, and LPN (F) (name) we only have termination. No mention was given for the other 2 staff LPN (G), and CNA (F) which were never received. The documents were reviewed and revealed that for all 6 staff members no annual evaluations nor competency evaluations had been completed in the past year. In review of the education records received, only 3 staff members had education records. For the 3 employees who did have education records (DON, CNA (B) and CNA (C) none of them had received education in mandatory training to include; Abuse/neglect, misappropriation, exploitation, dementia management, and abuse prevention. On 9-20-22 Director of Human Resources (Employee X) stated the employee training records were computer-based Relias training conducted in the facility. Employee X utilized her computer to facilitate the review, and provided copies to the Administrator to forward to the surveyors. The Director of Human Resources was asked who was responsible for clinical staff training, and she stated that it was the nursing departments' responsibility to ensure that the required training was completed. On 9-20-22 the Administrator, and the Director of Nursing (DON) were informed of the findings. When asked about the nursing departments' responsibility to ensure that nursing staff received the required training, the DON stated, I can't tell you about all of the required training. Staff are required to complete it online. I can follow-up with the Completion Report printed from Relias. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the course of the 2 week survey deficient practice was levied at Immediate Jeopardy (IJ), and harm, in the area of abuse/neglect and exploitation, and in not providing rehabilitative services. It was also found that accident hazards existed for a demented resident, an unsafe discharge was performed for a dependant resident, quality of life was deficient, quality of care was levied at harm in 3 areas to include pressure sores and range of motion, significant medication errors were found, and notices for advocacy agencies were not posted for resident use. Residents recounted allegations of fear and retaliation during the entire survey, and facility known resident allegations of abuse had gone unreported and uninvestigated by the facility, and logged in a grievance file. The lack of training for staff competency may have contributed to these outcomes. On 9-20-22 at the end of day debrief the Administrator and DON stated that all of the staff education records they had were given to the survey team. No further information was provided by the facility at the time of exit on 9-22-22 at 4:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 31199 Based on staff interview and facility documentation review, the facility staff failed to ensure that the required 12 hours per year of in-service training was completed for Certified Nursing Aides (CNA's). The survey sample of of 3 CNA's consisted of; (CNA B), (CNA C), and (CNA F). The Findings included: The Facility failed to ensure 12 hours of training annually for CNA's. On 9-14-22 a review was requested for employee education/training and competency evaluations. The facility Administrator was asked for employee records for the 6 staff members. Each day from 9-14-22 through 9-18-22 the employee records were requested, and surveyors were told by the Administrator oh yes, I have them on my desk, I will send them to your email. On 9-19-22 education records and evaluation information was received. There were 2 of the 3 included and a call was placed to the Administrator to ask for the other missing document. The 2 that were received stated on the email from the Administrator the following; CNA (C) (name) does not have an annual eval on file, CNA (B) (name) has none. No mention was made regarding CNA (F) which was never received. The documents were reviewed and revealed that for the 2 CNA staff members education records that were received, neither of them had received 12 hours of education in mandatory training. On 9-20-22 Director of Human Resources (Employee X) stated the employee training records were computer-based Relias training conducted in the facility. Employee X utilized her computer to facilitate the review, and provided copies to the Administrator to forward to the surveyors. The Director of Human Resources was asked who was responsible for clinical staff training, and she stated that it was the nursing departments' responsibility to ensure that the required training was completed, and the 12 hours of training was based on date of hire, not calendar year. On 9-20-22 the Administrator, and the Director of Nursing (DON) were informed of the findings. When asked about the nursing departments' responsibility to ensure that nursing staff received the required training, the DON stated, I can't tell you about all of the required training. Staff are required to complete it online. I can follow-up with the Completion Report printed from Relias. On 9-20-22 at the end of day debrief the Administrator and DON stated that all of the staff education records they had were given to the survey team. No further information was provided by the facility at the time of exit on 9-22-22 at 4:30 p.m.