DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495319	A. BUILDING _____ B. WING _____	C 08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIAN	9229 ARLINGTON BLVD FAIRFAX, VA 22031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted on 08/16/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. VA00055925- Substantiated with deficiency The census in this 81 certified bed facility was 68 at the time of the survey. The survey sample consisted of 3 resident reviews	F 000	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by The Virginian of the truth of the facts alleged in this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of corection serves as the allegation of compliance.	9/24/22
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, and interview the facility failed to maintain one resident free of accident hazards in a sample size of 3. The findings included: For Resident #2 the facility failed to transport the resident safely per wheelchair. The resident was transported without any foot rest. According to a nurse's progress note dated 07/23/22, Resident #2 fell on 07/23/22 from a	F 689	1. Resident #2 continues to reside in the facility under the care and supervision of the attending physician. No other residents have been identified as having been affected by the practice noted in the statement of deficiencies. 2. Residents who utilize wheelchairs for locomotion are considered at risk for injury for nonuse of footrests. Residents will be evaluated for wheelchair needs and footrests as indicated. 3. Residents are provided with wheelchair footrests unless contrary to resident wishes and/or preferences. All staff will be reeducated regarding transporting residents in wheelchairs to include the use of footrests. Residents who decline the use footrests will be screened by therapy for appropriate locomotion. Nursing assistant assignment sheets have been updated to include wheelchair needs. 4. Unit managers and charge nurses will monitor wheelchair use daily to ensure that footrests are used appropriately and submit reports to the Director of Nursing (DON)/designee weekly for eight weeks. 5. The DON submits audit results to the QAA committee monthly for two months for further review and recommendations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul Thorsen Administrator | TITLE | (X6) DATE: 8/31/22

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.

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F 689	Continued From page 1 wheelchair while being pushed per a certified nursing assistant (CNA). As evidenced by the nurse's progress note the resident did not have a foot rest in place at time of the incident. On 08/16/2022 at approximately 09:00 a.m., Resident #2 was interviewed. Resident #2 stated that she had a big fall. I do not want to get the lady in trouble who was pushing me in my wheelchair that day. However, before I could straighten up in my chair, she was pushing me toward the door and when I got to the door of my room, I fell out of my wheelchair. The facility does not have a policy that speaks to safe transportation in wheelchair per the Administrator. At end of day meeting, at 4pm, the interim Administrator, made known that residents are transported all the time in wheelchairs without footrest and stated that no one goes to get a footrest to transfer a resident in a wheelchair.	F 689		