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	06/04/2026

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 - Few	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** Based on observation, interview and clinical record review, the facility staff failed to ensure a safe clean, comfortable and homelike environment for all residents of the facility. The findings included: The facility staff failed to ensure the parking lot was free of trash and debris, failed to ensure the entry gate was in good repair and not an accident hazard and failed to ensure that the facility was odor free. The following observations were made throughout the three days of survey: On 6/2/26 at 1p.m, within the parking lot there were two face masks and one pair of used purple latex gloves (used turned inside out as if taken off and thrown down. Litter was throughout the parking lot area and on the grass. The wrought iron gate at the front entrance was wobbly and was not secured in the concrete on one side. During the entrance conference the Administrator notified survey team of one Resident using electronic monitoring. Request was made for the electronic monitoring policy. rooms [ROOM NUMBERS] had signs that deep cleaning was scheduled for 6/4/26, room [ROOM NUMBER] - was cluttered with personal property, shopping bags under bed, a stack of five towels, three wash cloths and two hospital gowns sitting on a chair, room [ROOM NUMBER] has a strong odor of urine.room [ROOM NUMBER] was very cluttered, room [ROOM NUMBER] and 237 are cluttered as well, room [ROOM NUMBER] had a strong odor of urine and body odor. On 6/3/36 at 11:00 AM, the gate to front of facility which was wrought iron and comprised of two side pieces that are supposed to be set in the concrete/ brickwork around porch and the gate itself that swings open. The left side piece was not steady in place it moves and is coming out of the concrete foundation. The surveyor spoke with Administrator about the observations and she stated that she is aware of this being an issue and would now take steps to fix the problem. On 6/3/26 at 3 p.m an interview was conducted with the Administrator, who shared documentation from 3/17/26 QAPI meeting. During the meeting the QAPI team identified Clutter present in resident rooms. The action plan created included pruchasing storage containers, Social Services was to identify highrisk rooms and assist with organizing their belongings. Ambassadors would identify and track progress of residents decluttering on room rounds, reviewed and added clutter to care plans as needed. The QAPI plan revealed that the process was on-going. She also shared that the deep cleaning and decluttering was a process that was ongoing and that they were rotating rooms on the deep cleaning schedule. On 6/4/26 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and clinical record review the facility failed to ensure a resident's right to be free from physical restraint for one resident (R1) in a survey sample of ten residents.For R1 the facility staff did not ensure proper the resident had the proper assessment and re-evaluations for continued use of restraints.R1 was admitted to the facility on [DATE] with diagnoses that include but were not limited to dysphagia post stroke, chronic obstructive pulmonary disease, tracheostomy status, gastrostomy tube, dementia, neuromuscular dysfunction of bladder, chronic respiratory failure, generalized anxiety disorder, major depressive disorder, gastro esophageal reflux disease. R1's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/14/26 coded R1 as having a BIMS (Brief Interview of Mental Status) score of 00 out of 15 indicating she could not be evaluated. R1 has dementia and is nonverbal due to her trach status. She used to be able to make needs known, however due to advanced dementia she cannot anymore. R1 is totally dependent on staff for all aspects of ADL care. R1 was bedbound with a contracted left hand. On her right hand she wore a mitten (restraint) due to incidents of pulling out her tracheostomy tube. On 6/2/26 at 2:45 pm, Observations were conducted of R1. R1 was observed laying in bed with no splint to the left hand, right hand has mitten restraint. R1 was dressed in a t-shirt and incontinence brief. Resident has trach with humidified oxygen, emergency supplies, ambu bag trach and inner cannula taped to wall above bed.On 6/3/26 at 10:29 am, R1 was in bed dressed in t shirt and incontinent brief and a sheet not covering legs, right hand mitten in place, R1 eyes closed, right hand is not visible due to mitten restraint. Review of the clinical record revealed the following order:Apply Mitten to right hand Q shift release for ten minutes every 2 hrs. as tolerated every shift for safety for removing Trach monitor for break edges and if dirty removed and replace extra from family supply or call family to replaced new ones. A review of the clinical record and observsations revealed staff following physician orders to remove the restraint every 2 hours for 10 min. A review of the clinical record revealed there were no assessment and reevaluation of continued need of restraint usage. A review of the ADL (Activities of Daily Living) record revealed the following documentation: Behavior Monitoring & Interventions wears right hand mitten for safety Each daily block was documented as NB (No Behavior) for the months of April, May, and June of 2026. On 6/3/26 the Director of Nursing (DON) and Administrator were asked to provide any documentation of initial evaluation and subsequent re-evaluationn of continued need for restraint. On the morning of 6/4/26 the DON reported that R1 has been in the facility since 2019 and they could not locate the initial assessment for the need of a restraint. R1 has documentation in the chart of pulling trach out however there was no documentation of a formal assessment or re-evaluation for continued need of the restraint as required. A review of the facility policy revealed:Policy: It is the policy of this facility that each resident shall attain and maintain his/herhighest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Compliance Guidelines:1. The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms.2. Physical restraints may be used in emergency care situations for brief periods to permit medically necessary treatment that has been ordered by a practitioner, unless the resident has previously made a valid refusal of the treatment in question. Falls do not constituteself-injurious behavior or a medical symptom that warrants the use of a physical restraint.3. Behavioral interventions should be used and exhausted prior to the application of a physical restraint.4. A physician's order alone is not sufficient to warrant the use of a physical restraint. The facility is responsible for the appropriateness of the determination to use a restraint.5. Before (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident is restrained, the facility will determine the presence of a specific medical symptoms that would require the use of restraints, and determine:a. How the use of restraints would treat the medical symptom.b. The length of time the restraint is anticipated to be used to treat the medical symptom, who may apply the restraint, and the time and frequency that the restraint will be released.c. The type of direct monitoring and supervision that will be provided during use of the restraint.d. How the resident will request staff assistance and how his/her needs will be met while the restraint is in place.e. How to assist the resident in attaining or maintaining his/her highest practicable level of physical and psychosocial well-being.6. Medical symptoms warranting the use of restraints should be documented in the resident's medical record. The resident's record needs to include documentation that less restrictive alternatives were attempted to treat the medical symptom but were ineffective, ongoing reevaluation of the need for the restraint, and the effectiveness of the restraint in treating the medical symptom. The care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint.7. The resident/resident's representative may request the use of a physical restraint; however, the facility is responsible for evaluating the appropriateness of the request, and must determine if the resident has a medical symptom that must include the practitioner in the review and discussion. If there are no medical symptoms identified that require treatment, the use of the restraint is prohibited. The facility shall explain to the resident/resident's representative, the potential risks and benefits of using a restraint, not using a restraint, and alternatives to restraint use. Potential negative outcomes should also be explained including, but not limited to:a. Decline in physical functioningb. Decreased muscle conditionc. Contracturesd. Increased risk for infectione. Pressure ulcers/injuriesf. Deliriumg. Agitationh. Incontinencei. Accidents such as falls, strangulation, or entrapmentj. Loss of autonomy and dignityk. Withdrawal or reduced social contact8. The resident/resident's representative has the right to refuse the use of a restraint and may withdraw consent to use the restraint at any time. The refusal must be documented in the resident's record. The facility will assess the resident and determine how the resident'sneeds will be met if the resident refuses/declines treatment.9. If a resident is admitted to the facility and a restraint was used in a previous health care setting, the facility must still conduct an assessment to determine the existence of medical symptoms that warrant the continued use of the restraint, that include, but not limited to:a. Interventions, including less restrictive alternatives were attempted to treat the medical symptom but were ineffective.b. The resident/resident's representative was informed of potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use.10. A device that is utilized by the resident that was placed by the facility and has been determined by the facility that the resident can remove requires demonstration by the resident of removal of the device without staff providing specific instructions for theremoval. On 6/4/26 during the end of day meeting the Administrator was made aware of the concern, and no further information was provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure residents receive the necessary services to maintain good grooming, and personal hygiene, for one resident (R1) in a survey sample of ten residents.For R1 the facility staff failed to ensure the resident had adequate grooming to include nail care. R1 was admitted to the facility on [DATE] with diagnoses that include but were not limited to dysphagia post stroke, chronic obstructive pulmonary disease, tracheostomy status, gastrostomy tube, dementia, neuromuscular dysfunction of bladder, chronic respiratory failure, generalized anxiety disorder, major depressive disorder, gastro esophageal reflux disease. R1's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/14/26 coded R1 as having a BIMS (Brief Interview of Mental Status) score of 00 out of 15 indicating she could not be evaluated. R1 has dementia and is nonverbal due to her trach status. She used to be able to make needs known, however due to advanced dementia she cannot anymore. R1 is totally dependent on staff for all aspects of ADL care. R1 was bedbound with a contracted left hand. On her right hand she wore a mitten (restraint) due to incidents of pulling out her tracheostomy tube. The following observations were made of R1: On 6/2/26 at 2:45 pm, R1 was observed laying in bed with no splint to the left hand, right hand has mitten restraint. Lef hand fingernails are observed to be long. R1 was dressed in a t-shirt and incontinent brief. R1 has trach with humidified oxygen, emergency supplies, ambu bag trach and inner cannula taped to wall above bed. On 6/3/26 at 10:29 am, R1 was again observed in bed dressed in a t-shirt and incontinent brief and a sheet not covering legs, right hand mitten in place, R1 eyes were closed, and there was an odor in room. R1's left hand does not have splint as stated in care plan and orders. The left hand nails are long more than 1/4 inch over nail bed, right hand is not visible due to mitten restraint. On 6/3/26 at 2:10 pm, the DON (Director of Nursing) donned [put on] gloves, isolation gown and carefully opened R1's left hand which was contracted, to view the palm. There was no visible injury from nails however the DON stated he believed podiatry cuts her nails. When asked how often podiatry comes to the building he stated monthly. The DON released restraint from right hand and examined palm nails also long on the right hand however no damage to the hand from nails. On 6/3/26 at 3:30 pm, the DON notified the surveyor that podiatry cuts R1 toenails and the unit manager is the one who cuts the resident's fingernails. On 6/3/36 a review of the ADL policy revealed the following: Definitions: Nail hygiene services: refers to routine trimming, cleaning, filing but not polishing of undamaged nails, and on an individual basis, care for ingrown or damaged nails. Hair hygiene services: refers to the routine combing, brushing, shampooing, trimming and simple haircuts Policy: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. This facility will provide routine care for the resident for hygienic purposes and for the psychosocial well-being of the resident including but not limited to hair hygiene that includes combing, brushing, shampoo, trimming and simple haircuts. Routine care also includes nail hygiene services including routine trimming, cleaning and filing. Routine Nail hygiene and hairhygiene may be performed in conjunction with bathing or performed separately. Care for ingrown or damaged nails will be provided on an individual care need basis. These services are provided by the facility as part of regular grooming care. Nail care for diabetic residents will be completed by a licensed nurse. Procedure: I. Routine Nail Hygiene a. Residents will have routine nail hygiene and hair hygiene as part of the bath or shower i. Nails should be trimmed immediately after bathing or alternatively, soaking nails in warm soapy water prior to trimming or filing to reduce tearing and provide ease of trimming and filing. A review of the clinical record revealed the documentation on the ADL (Activities of Daily Living) record of R1 receiving 2 bed baths per week for the months of April, May and June of 2026, there was no documentation of hair being washed, nor nails being trimmed. On 6/4/26 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0688 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure receive asppropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one resident (R1) in a survey sample of ten residents.The findings include: For R1 the facility staff failed to ensure the left hand splint was applied as ordered by the physician for the express purpose of preventing worsening of contractures. R1 was admitted to the facility on [DATE] with diagnoses that include but were not limited to dysphagia post stroke, chronic obstructive pulmonary disease, tracheostomy status, gastrostomy tube, dementia, neuromuscular dysfunction of bladder, chronic respiratory failure, generalized anxiety disorder, major depressive disorder, gastro esophageal reflux disease. R1's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/14/26 coded R1 as having a BIMS (Brief Interview of Mental Status) score of 00 out of 15 indicating she could not be evaluated. R1 has dementia and is nonverbal due to her trach status. She used to be able to make needs known, however due to advanced dementia she cannot anymore. R1 is totally dependent on staff for all aspects of ADL care. R1 was bedbound with a contracted left hand. On her right hand she wore a mitten (restraint) due to incidents of pulling out her tracheostomy tube. A review of the clinical record revealed the following order: Device: wear left resting hand splint 6 hours per day. Donn at 10:00AM and doff at 4:00 PM . every day and evening shift Complete Skin Checks and remove for hygiene. The following observations were made regarding R1's use of splint. On 6/2/26 at 2:45 pm, R1 was observed laying in bed with no splint to the left hand, the right hand had a mitten restraint. R1 was dressed in a t-shirt and incontinent brief. R1 was noted to have a trach with humidified oxygen, emergency supplies, ambu bag trach and inner cannula taped to wall above bed. On 6/3/26 at 10:29 am, R1 was again observed in bed, dressed in a t-shirt and incontinent brief with a sheet not covering legs, right hand mitten was in place, R1's eyes were closed. The right hand was not visible due to mitten restraint. On 6/3/26 at 1pm an interview was conducted with a certified nursing assistant (CNA 2) who stated The nurse is supposed to put the splint on because she has to sign it off in her documentation. On 6/3/26 at 1:25 pm an interview with a licensed practical nurse (LPN 1) was conducted and LPN 1 stated that nurses put the splints on and off since they are responsible for the documentation in the chart. On 6/3/26 at 2:10 pm, an interview was conducted with the DON (Director of Nursing) who stated that it is the expectation of the facility that physician orders are followed and splints are put on as ordered by the physician. On 6/4/26 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure that tracheostomy care was provided in accordance with standards of practice for one resident (Resident 1 (R1)) in a survey sample of ten residents. The findings included: For R1the facility staff failed to use proper procedure and documentation of tracheal care and suctioning, R1 was admitted to the facility on [DATE] with diagnoses that include but were not limited to dysphagia post stroke, chronic obstructive pulmonary disease, tracheostomy status, gastrostomy tube, dementia, neuromuscular dysfunction of bladder, chronic respiratory failure, generalized anxiety disorder, major depressive disorder, gastro esophageal reflux disease. R1's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/14/26 coded R1 as having a BIMS (Brief Interview of Mental Status) score of 00 out of 15 indicating she could not be evaluated. R1 has dementia and is nonverbal due to her trach status. She used to be able to make needs known, however due to advanced dementia she cannot anymore. R1 is totally dependent on staff for all aspects of ADL care. R1 was bedbound with a contracted left hand. On her right hand she wore a mitten (restraint) due to incidents of pulling out her tracheostomy tube. On 6/3/26 observations were conducted of licensed practical nurse #1 (LPN 1) providing tracheostomy care and suctioning on R1 On 6/3/26 at 12:00pm, LPN 1 was again observed performing trach care and suctioning LPN 1 assembled equipment, performed hand hygiene, donned [put on] personal protective equipment (ppe), proceeded to set up and turn on suction, removed the inner cannula, placed it in saline solution to clean, attached suction cannula and introduced it 4-6 inches in trach, withdrew cannula applying suction on withdrawal, cleared cannula using normal saline, repeated procedure several times. LPN 1 did not explain procedure, assess lung sounds prior to or post suctioning, nor did LPN 1 check R1's oxygen saturation (pulse ox). On 6/3/26 at approximately 3:30 pm an interview was conducted with the DON (Director of Nursing) who stated it is the expectation of the facility that nurses follow the trach and suction policy and procedure of the facility each time they suction and provide trach care. The DON stated that the professional standard used by the facility is [NAME]. Per [NAME] lww.comLippincott procedures. Tracheostomy Suctioning. November 28, 2022. Lippincott procedures -Tracheostomy suctioning (lww.com)Policy: Residents may require suctioning by a licensed, competent nurse or respiratory therapist to clean the throat and upper respiratory tract of secretions that may block the airway. Process steps may be performed using a different sequence and does not imply incorrect procedure. Each resident's care will be based upon an assessment of their medical needs, and the resources available at the time of the procedure in consideration of emergency needs.Procedure:A. Open Suctioning System:1. Gather equipment and set up, attach suction tubing to canister.2. [NAME] appropriate PPE3. Explain the procedure to the patient and screen for privacy.4. Auscultate pre procedure lung sounds5. Suctioning can be a frightening experience; allow the patient an opportunity to catch his/herbreath between episodes of suctioning.6. Position patient semi to high fowler's, if tolerated7. Wash hands.8. Place sterile towel (paper) on table.9. Place cup on sterile area, pour approximately 50-100cc sterile water or saline into cup.10. Put on sterile gloves.11. Attach suctioning tip to the connecting tubing.12. Turn on suction source. Remembering to keep one hand sterile. Set the pressure between 80-120mmHg for adults.13. Insert catheter into tracheostomy tube opening gently during inspiration until resistance is felt or patient starts to cough. DO NOT apply suction while inserting.14. Withdraw catheter about inch15. Place finger over catheter suction port approximately 10-12 seconds.16. Rotate and withdraw catheter smoothly. Rinse tubing by suctioning the sterile water or saline through the suction tubing to clear the tubing if necessary.17. Repeat tracheostomy suctioning if necessary.18. Clean the trach site and position patient comfortably.19. Post Procedure:a. After completion of suctioning, wrap the suction catheter around the gloved hand; pull the glove over the coiled catheter and discard both into the designated container.b. Replace a (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disposable suction collection canister, as necessary (at least weekly).c. Rinse and clean a non-disposable suction collection canister, as necessary ifsecretions are adhered to the container, discard or disinfect, as appropriate.d. Remove PPE and perform hand hygienee. Auscultate lung sounds and obtain oxygen saturation reading Documentation:1. Document the procedure and resident tolerance in the medical record2. Document pre and post lung sounds, oxygen saturation level and any significant findings. On 6/4/26 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility documentation the facility staff failed to prepare, food in accordance with professional standards for food service safety for all residents who recieve food from the kitchen. For all residents receiving food from the kitchen, other employee one did not wear a beard guard while preparing salads in the kitchen to reduce the risk of food contamination. On 6/3/26 at 9:00 a.m. a dietary aide (other employee 1) was observed packaging/dating the salads without a hair net or beard guard on. At 9:05 a.m., an interview was conducted with other employee 1 who stated that he forgot to put on the beard guard. At 9:15 a.m., an interview was conducted with the Dietary Manager who stated that it is the expectation of the facility that all staff use appropriate head and beard covering at all times in the kitchen. A review of the facility policy revealed the following excerpt: Authorized Kitchen Personnel Policy: .2. All authorized personnel must wear appropriate head covering while i the kitchen or production area (e.g. hair off the shoulders, confined in a hair net or cap and facial hair properly restrained.) . On 6/4/26 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.