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The Virginian(Fairfax Co)
9229 Arlington Blvd.
Fairfax, VA 22031
(571) 568-8733

Current Inspector: Amanda Velasco (703) 397-4587

Inspection Date: March 29, 2021

Complaint Related: No

Areas Reviewed:

22VAC40-73 RESIDENT CARE AND RELATED SERVICES

Comments:

A non-mandated self-report inspection was initiated on 3/29/21 and concluded on 8/6/21. A self-reported incident was received by the department regarding an allegation in the area of: Resident Care and Related Services. The administrator was contacted by telephone to conduct the inspection. The licensing inspector emailed the administrator a list of documentation required to complete the investigation. The licensing inspector conducted on-site observations at the facility on 6/17/21 and 7/14/21.

The evidence gathered during the investigation supported the self-report of non-compliance with standards or law, and a violation was issued. Any violations not related to the self-report but identified during the course of the investigation can be found on the violation notice.

Violations:

Standard #:	22VAC40-73-460-D
Description:	Based on record review and documentation, the facility failed to ensure supervision of resident schedules, care, and activities, including attention to specialized needs, such as prevention of falls and wandering from the premises. Evidence: Resident #1 eloped from the special care unit on 3/28/21. Facility staff reported that Resident #1 was able to leave the unit by following a visitor, while he was exiting the unit. Resident #1 reportedly asked for a ride from the visitor, but the visitor declined the request. Resident #1 then reportedly walked away in the rain. Shortly after Resident #1 was discovered to be missing by facility staff, her daughter called to report that Resident #1 was at a friend?s house. The house is approximately a quarter of a mile from the facility. The record for Resident #1 contains an assessment of serious cognitive impairment, dated 10/28/20, that states that Resident #1 has a serious cognitive impairment and that she is unable to recognize danger or protect her own safety and welfare.
Plan of Correction:	1. No harm came to this Resident, who was immediately assessed by our nursing department. 2. The egress doors were immediately checked by Plant Operations to ensure they were in working order. 3. We educated our community about the egress delay, and staff and family members know to wait on the outside of the door, to ensure no one has followed them. All staff are now in the habit of doing so, and we have educated family members as well. 4. We are in the process of investigating different types of locking mechanisms for our renovated unit, to be completed

within a few months. In the meantime, the Fire Marshal's office has approved our current system. We will strive to maintain stricter vigilance when visitors and staff are leaving the unit.

Disclaimer:
This information is provided by the Virginia Department of Social Services, which neither endorses any facility nor guarantees that the information is complete. It should not be used as the sole source in evaluating and/or selecting a facility.