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

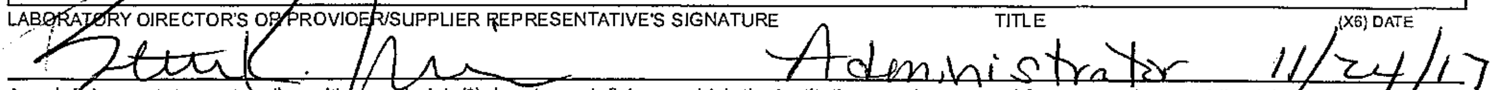
PRINTED: 11/16/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495410	A. BUILOING ______ B. WING ______	11/15/2017

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
ARLEIGH BURKE PAVILION	1739 KIRBY ROAO MC LEAN, VA 22101

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/13/17 through 11/15/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 49 certified bed facility was 44 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents # 1 through #10) and three closed record reviews (Residents # 11 through # 13).	F 000	RECEIVED NOV 27 2017 VDH/OLC	
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other	F 371	It is the facility's policy to store and prepare food in accordance with professional standards for food service safety. While both the German chocolate cake and the whipped topping were wrapped they were not stored with a use by date. Both items where immediately discarded on November 13, 2017. Upon discovery that there was water in the Food Processor bowl and the blade was wet. The Food Processor parts were re-washed and sanitized and allowed to air dry before assembly, November 13, 2017.	12/20/16

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



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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visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined, the facility staff failed to store and prepare food in a clean and sanitary manner.

The findings include:

Observation and tour of the kitchen was conducted on 11/13/17 at approximately 6:45 p.m. with OSM (other staff member) # 6, the cook. The following was observed:

Half of a nine inch, double layer German chocolate cake, wrapped in plastic was observed on top of a shelf in the walk-in refrigerator. There was no label or date indicating when the cake was opened. When asked when the cake was opened and cut, OSM #6 stated she didn't know and immediately removed the cake from the walk-in refrigerator and disposed of it.

A 16-ounce tube of whipped topping containing approximately a quarter of whipped topping, wrapped in plastic was lying on a shelf in the walk-in freezer. There was no label or date indicating when the whipped topping was opened. When asked when the whipped topping was opened, OSM #6 stated she didn't know and immediately removed the whipped topping from the walk-in freezer and disposed of it.

A food processor was observed on the food preparation table. OSM #6 was asked if the food processor was cleaned and ready for use, she stated, "Yes." Further observation of the food

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Upon discovery that there was food debris on the neck of the mixer, other surfaces that would come in contact with food items were found to be clean, all areas of the mixer were immediately properly cleaned and sanitized, November 13, 2017.

On November 13, 2017 the meat slicer was dis-assembled and properly cleaned and sanitized.

The facilities policy and procedures have been reviewed. The following steps will be taken to ensure compliance related to food storage.

- Charts will be displayed for proper storage protocols for specific items for easy/quick reference for all kitchen staff.
- The Dining Services staff will receive and in-service training regarding storage protocols and the use of the reference charts to ensure proper labeling and dating of all foods stored.
- Checklist developed for kitchen personnel to complete daily to ensure compliance and to take corrective action on the spot.

The dining services manager will conduct audits weekly of all areas to ensure proper labeling and dating all food items. The findings of the

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processor revealed the processing bowl on the stand with the with the blade attached inside the bowl and a plastic lid on the bowl. An examination of the inside of the bowl revealed a small pool of water in the bottom of the bowl and the blade was wet. OSM #6 was asked to examine the inside of the food processor bowl. When asked if there was standing water in the bottom of the bowl and if the blade was wet, OSM #6 stated, "Yes." When asked if the parts of the food processor were to be stored wet, OSM #6 stated, "No" and immediately had them removed to be washed.

A mixer was observed on the food preparation table. OSM #6 was asked if the mixer was cleaned and ready for use, she stated, "Yes." Further observation of the mixer revealed food debris on the neck of the mixer. OSM #6 was asked to examine the neck of the mixer. When asked if the part was clean, OSM #6 stated, "No." When asked if the neck of the mixer should have been cleaned, OSM #3 stated, "Yes" and immediately instructed another staff member to wash the mixer.

A meat slicer was observed on the food preparation table covered with a plastic bag. OSM #6 was asked if the meat slicer was cleaned and ready for use, she stated, "Yes." OSM #6 was then asked to uncover the meat slicer. Further observation of the meat slicer revealed dried food debris on the housing behind and beneath the blade. OSM #6 was asked to examine the housing behind and beneath the blade. When asked if the meat slicer was clean, OSM #6 stated, "No" and immediately instructed kitchen staff to take the meat slicer apart and wash it.

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audits will be documented and reported to the QAPI committee for further monitoring and process review.

The facilities policy and procedures for "Cleaning Instructions" have been reviewed. The following steps will be taken to ensure compliance.

- The facilities policy will updated to include cleaning and sanitizing equipment both *after* and *before* each use. This was added to assure the cleanliness of each piece of equipment before use especially if the item had not been used for an extended period of time.
- The Dining Services staff will receive and in-service training regarding the change in policy and to assure the proper cleaning and drying of all equipment.
- Checklist developed for kitchen personnel to complete daily to ensure compliance and to take corrective action on the spot.

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On 11/14/17 at approximately 9:00 a.m. an interview was conducted with OSM # 2, dietary manager regarding the findings of the kitchen tour on 11/13/17 with OSM # 6. OSM # 6 stated the cake and the whipped topping should have been dated when opened; the food processor should have been stored dry and the mixer and meat slicer should have been cleaned.

The facility's policy "Cleaning Instructions: Food Preparation Appliances" documented in part, "Policy: Small appliances (such as food processors) will be cleaned and sanitized after each use. Procedure: 5. Air Dry."

The facility's policy "Cleaning Instructions: Slicers" documented in part, "The slicer will be cleaned and sanitized after each use."

The facility's policy "Food Storage" documented in part, "13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded."

Food Code 2009 Recommendations of the United States Public Health Service Food and Drug Administration.
4-601.11 Equipment Food-Contact Surfaces, Nonfood-Contact Surfaces and Utensils.
(A) Equipment food-contact surfaces, nonfood-contact surfaces and utensils shall be clean to sight and touch.
(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.

The dining services manager will conduct audits weekly of all areas to ensure the equipment is being cleaned and sanitized and dried according to policy. The findings of the audits will be documented and reported to Monthly to the QAPI committee for review and further action.

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F 371	Continued From page 4 On 11/14/17 at approximately 5:30 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing were made aware of the findings. No further information was obtained prior to exit.	F 371		
F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined, the facility staff failed to ensure timely physician visits for two of 13 residents in the survey sample, Residents # 1 and # 5. 1. The facility staff failed to ensure that Resident # 1 was seen by a physician from 3/23/17 to 7/31/17, a total of 129 days. 2. The facility staff failed to ensure physician visits were conducted every 60 days for Resident #5. The clinical record documented the physician visited Resident #5 on 03/30/17 then not again till 07/27/17, (119 days between visits). The findings include:	F 387	It is the facility's policy to have our residents seen by physicians at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. Resident #1 was seen by her attending physician 7//31/17 and then by the Medical Director on 9/29/17. After repeated attempts by the facility to have her physician visit within the 60 day timeline as required, the facilities Medical Director was asked to see the resident. Resident #5 was seen by her attending physician 7/27, 8/5, 8/24, 9/21, 10/5,10/19, 10/26 and 11/14. A facility wide audit of all physician visits has been conducted with no additional infractions.	12/15/17

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1. The facility staff failed to ensure that Resident # 1 was seen by a physician from 3/23/17 to 7/31/17, a total of 129 days.

Resident # 1 was admitted to the facility on 8/9/12 and most recently admitted on 3/10/14, with diagnoses that included, but were not limited to: congestive heart failure, diabetes, gastroesophageal reflux disease, hyperlipidemia, and arthritis.

Resident # 1's most recent MDS (minimum data set) an annual assessment with an ARD (assessment reference date) of 10/27/17 assessed Resident # 1 as usually understood by others and usually able to understand others. Resident # 1 was coded as scoring a 10 out of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was moderately cognitively impaired.

A review of Resident #1's clinical record revealed progress notes that were dated 3/23/17 and 7/31/17, a total of 129 days between notes. No other physician notes were provided.

During an interview on 11/14/17 at 5:35 p.m. with ASM (Administrative Staff Member) # 1, the Administrator, ASM # 2, the Director of Nurses, and OSM (Other Staff Member) # 3, the Social Worker, this concern was revealed and a request was made for any other physician notes that could be found between 3/23/17 and 7/31/17.

During an interview on 11/15/17 at 8:50 a.m. with ASM # 1, ASM # 1 stated staff had been having difficulty getting (name of Resident # 1's) physician to come in to the facility to see her. At

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The facilities policy and procedure has been reviewed with the Medical Director. The following steps have been taken to ensure compliance:

- Medical Records Personnel will monitor and track MD visit schedule.
- Medical Records Personnel to provide status of Physician Visits due monthly to the Administrator and DON.
- The Medical Director will be notified of all Physician Visits out of compliance at the 30 day point for his intervention.
    - Call and confirm physician visits
    - See residents to prevent past due visits.

All Physician visits will be monitored as a part of our QAPI program and any noncompliance of physician visits will be reported and monitored to ensure corrective action was taken.

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this time a time line of attempts made to have the physician come in to see the Resident #1 was presented. ASM # 1 was asked which staff member was responsible for keeping track of physician visits. ASM #1 stated (name of OSM # 7), the medical records staff member was responsible. A request was made to interview this staff member.

During an interview on 11/15/17 at 10:16 a.m. with OSM # 7 (ASM # 1 was present during this interview and ASM # 2 walked into the room while the interview was in progress), OSM # 7 was asked what process is followed to keep track of physician visits. OSM # 7 stated she must make sure that the physician comes in on time - every 60 days. OSM # 7 stated there is a binder for each physician that has the due dates that each resident is to be seen. OSM # 7 stated, "I check each binder to see if the physician has seen those residents that are due and if the residents have not been seen I call the physician to remind them. If after another week the residents have not been seen I make a report to the Administrator and the Director of Nurses. I also make notes in the computer of the dates and times I have called the physician." OSM # 7 identified the notes presented by ASM # 1 as her (OSM # 7's) notes.

During an interview on 11/15/17 at 12:07 p.m. with ASM # 1 and ASM # 2, this concern was again reviewed.

Review of the facility policy: "PHYSICIAN SERVICES and MEDICAL SUPERVISION OF RESIDENTS...# 6. Each resident's total program of care shall be reviewed and revised at intervals appropriate to his needs. Residents must be

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seen by a physician at least once every thirty (30) days for the first ninety (90) days after admission and at least every sixty (60) days thereafter..."

No further information was provided prior to exit.
2. The facility staff failed to ensure physician visits were conducted every 60 days for Resident #5. The clinical record documented the physician visited Resident #5 on 03/30/17 then not again till 07/27/17, (119 days between visits).

Resident #5 was admitted to the facility on 08/13/13 with diagnoses that included but were not limited to: atrial fibrillation (1), heart failure, diabetes mellitus without complication (2), edema (3), and Alzheimer's disease (4).

Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/20/17, coded Resident #5 as scoring a two on the brief interview for mental status (BIMS) of a score of 0 - 15, two being severely impaired of cognition for making daily decisions. Resident #5 was coded as requiring limited assistance of one staff member for activities of daily living.

A review of the clinical record revealed the physician visited Resident #5 on 03/30/17 then not again till 07/27/17, 119 days between visits.

On 11/15/17 at approximately 9:00 a.m. ASM (administrative staff member) #2, the director of nursing provided this surveyor with a "Progress Note" by Resident #5's physician. The note was signed by the physician but was not dated. The "Progress Note" documented, "Dates of visits reviewed. There was a gap form March 30, 2017 to July 27, 2017. It is highly unlikely that I did not

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see (Resident #5) in that interval. She is in the day area often during my Thursday visits and I check her frequently. If it is important to know, I can check the billing personal to see if I submitted an additional visit in the gap."

On 11/15/17 at 10:20 a.m. an interview was conducted with OSM (other staff member) # 7, director of medical records. When asked how often a resident needs to be seen by the physician, OSM # 7 stated, "One time per month for the first three months and every sixty days afterwards." When asked how he ensures the physician sees the residents every sixty days, OSM #7 stated, "Each physician has a binder and it has a log of their residents and the due dates for visits/notes. I check the binders on a monthly basis. If a physician is late I call the physician. If a note/visit is not done after a week I notify the administrator and call the physician again and make a note that I've contacted the physician." When asked if she had the note of when Resident #5's physician was contacted, OSM #7 stated, "No. It was an oversight for (Resident #5's) physician because he is in the facility every Thursday to see (Resident #5) and I didn't check."

On 11/15/17 at approximately 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing were made aware of the findings.

No further information was obtained prior to exit.

References:

1. A problem with the speed or rhythm of the heartbeat. This information was obtained from

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F 387	Continued From page 9 the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. 2. A chronic disease in which the body cannot regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm. 3. A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. 4. A brain disorder that seriously affects a person's ability to carry out daily activities) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.	F 387		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 441	It is the facility's policy to maintain an infection prevention and control program in order to provide a safe, sanitary environment to help prevent development and transmission of communicable diseases and infections.	12/15/17

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arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed

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On November 15, 2017 the fan was cleaned then removed from clean linen room and ceiling vent and surrounding tiles cleared of all dust and lint.

A cover has been ordered for clean linen cart on November 22, 2017. The cover will provide protection to the clean linen.

A facility wide tour was conducted with no additional infractions.

The facility's policy and procedures and practices for cleaning the Laundry Area were reviewed. The following changes have been made:

- Laundry personnel will clean using a checklist daily
- Manager will complete a quality control checklist weekly to ensure compliance.

The daily checklist and quality control checklist will be reviewed monthly for compliance and effectiveness. The Housekeeping/Laundry manager will report Monthly to the QAPI committee the effectiveness of the Checklists and the committee will take further action, if needed.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495410	A. BUILDING ______ B. WING ______	11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLEIGH BURKE PAVILION	1739 KIRBY ROAD MC LEAN, VA 22101

(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
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by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined, the facility staff failed to process and store linens in a sanitary manner.

The facility staff failed to keep air vent and fans free of dust when folding and storing clean linens.

The findings include:

On 11/15/17 at 11:30 a.m. an observation of the facility's laundry room was conducted with OSM (other staff member) #8 maintenance manager, OSM #9, director of facility and environmental services, OSM #10, housekeeping account manager, and OSM #11, laundry staff.

The laundry room consisled of a dirty linen room that contained a commercial clothes washer and soiled linens and soiled resident clothing. Another separate room adjacent to the soiled linen room was the clean laundry area. The area contained two commercial clothes dryers, table for folding clean linens and clothing. The area also contained a clean laundry rack measuring 60

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inches wide by 24 inches deep and 58 inches high with four shelves and a clean laundry cart filled with clean bed pads to be folded. Further observation of the table for folding clean linen revealed 34 clean and folded washcloths and a clean and folded bath blanket. The laundry cart with the clean bed pads was in front of the clean folding table uncovered. The clean laundry rack contained numerous clean and folded towels, bed sheets and resident clothing and was observed to be uncovered.

Further observation of the clean laundry area revealed a table top fan sitting on top of a refrigerator across from the clan folding table and the clean laundry cart. The fan was blowing toward the clean folding table and over the top of the clean laundry cart. OSM #11 was asked to turn the fan off. Observation of the fan revealed the fan blades and the front and rear finger guards were covered with grey dust/lint. Observation of the ceiling above the clean folding table and clean laundry cart revealed a 24 by 24-inch ceiling vent with diffuse baffles blowing air in four directions of the clean laundry area. Further observation of the ceiling vent revealed the diffuse baffles were coated with grey colored dust and the surrounding ceiling tiles around the vent were observed with pieces of dust and lint hanging from them.

When asked about the process of cleaning the fans and air vents OSM #11 stated they are cleaned every Friday. OSM # 1 was asked to turn off the table top fan that was blowing in the clean linen folding room. When asked if the fan was clean, OSM #11 stated no and agreed the fan blades and finger guards were covered in dust/lint. When asked if the clean washcloths

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and laundry cart with the clean bed pads should have been set and folded in front of the dirty table top fan, OSM #11 stated, "No." OSM #9, OSM #10 and OSM #11 were then asked to observe the ceiling air vents and the clothes racks in the room. Upon observing the vent OSM #10 and OSM #11 agreed the vent and surrounding ceiling tiles were coated with dust/lint. They further agreed the clean laundry rack was exposed to the air being blown from the ceiling vent. OSM #11 further stated she did not notice how dirty the fan or ceiling vent was. OSM #11 stated all the clean clothing and linen on the folding table, laundry cart and laundry rack would be removed immediately and rewashed.

OSM #10, housekeeping account manager, stated the fan and vent would be cleaned immediately and a plan would be put in place to address the cleaning of the fan and vent.

On 11/15/17 at approximately 12:10 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the findings.

No further information was obtained prior to exit.

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