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 _____	01/31/2019

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/29/19 through 1/31/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	POC ABP 2019 The statements made in this plan of Correction are Not an admission to and do not constitute an Agreement with the alleged deficiencies. To remain in compliance with all Federal and State regulations, the center has taken or will take the Actions set forth in this plan of correction. The plan of Correction constitutes the centers allegation of Compliance such that all alleged Deficiencies cited have been or will be corrected by the date or dates indicated.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/29/19 through 1/31/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 49 certified bed facility was 47 at the time of the survey. The survey sample consisted of 22 resident reviews.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would	F 622	F 622 Transfer and Discharge Requirements 1.Resident #43 had no adverse effects. 2.All residents receiving care have the potential to be affected. 3.The facility will conduct an audit of all residents to assure they have comprehensive care plan goals. 4. The facility has instituted a new form and a new process to assure that all residents transferred will have a set of comprehensive care plans provided for a hospital transfer. A. All hospital transfers will be reviewed daily In Hawk Room to assure a copy of the comprehensive care plans were provided to the hospital, If not they will be faxed that day. B. Education will be provided to all Nursing staff on the new process. 5. In order to assure on going compliance the facility will conduct a random audit of 4 transfer records, this audit will be conducted weekly X weeks and monthly X 4 months. 6. All findings will be submitted to QA for review and recommendations. 7. The corrective action will be completed by February 15, 2019.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert K. DeMaria	ADMINISTRATOR	02/08/2019

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 622	Continued From page 1 otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section.	F 622		

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F 622	Continued From page 2 (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to evidence all required documents were provided to the receiving hospital for a facility initiated transfer for one of 22 residents in the survey sample, Resident #43. The facility staff failed to evidence that Resident #43's comprehensive care plan goals were	F 622		

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F 622	Continued From page 3 provided to the receiving provider for a facility initiated hospital transfer dated 12/1/18. The findings include: Resident #43 was admitted to the facility on 1/6/2014 with a most recent readmission date of 12/6/2018. Diagnoses included but were not limited to: dementia with Lewy bodies (1), atrial fibrillation (2), pneumonitis (3), and Parkinson's disease (4). The most recent MDS (minimum data set), a Medicare five day assessment, with an ARD (assessment reference date) of 12/15/18 coded the resident as having a score of three on the BIMS (brief interview for mental status) score, indicating the resident had severe cognitive impairment. Review of Resident #43's clinical record revealed that she was sent to the hospital on 12/1/18. A nursing note dated 12/1/18 at 4:27 p.m., documented "Assessment done, daughter at bedside nurse observed pt (patient) congested, vital signs 130/70, 84, 99.3, O2 sat 92% room air (Sic). Supervisor made aware of patient recent vitals and patient congestion. Supervisor left a message for MD (medical doctor) about 11:30 a.m. at about 11:45 a.m. called placed to MD, MD updated of patient above condition, new order given to transfer patient to (name of Hospital) for further eval. (evaluation). Daughter at bedside made aware of MD orders. Daughter stated 'Thanks for everything' at about 12:15 p.m. Patient left facility awake and responsive via stretcher accompanied by 911 (emergency medical services) squad. Report given to (name of receiving provider) at (name of hospital) about	F 622		

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F 622	Continued From page 4 12:28 p.m." There was no evidence in the clinical record that Resident #43's comprehensive care plan goals were sent to the receiving provider for Resident #43's facility- initiated transfer to the hospital dated 12/1/18. On 1/30/19 at 1:16 p.m., an interview was conducted with LPN (licensed practical nurse) #3, unit manager. LPN #3 was asked what information is provided to hospital staff when a resident is transferred to the hospital. LPN #3 replied, "We send the face sheet, doctor's order, a physician order sheet, code status, a doctor's progress note, and a transfer form which summarizes the residents ADL's (activities of daily living). When asked if the facility provides the residents' the comprehensive care plan goals to the receiving provider, LPN #3 replied "No." On 1/31/19 at approximately 8:24 a.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Nursing. ASM #2 was asked if the facility could evidence comprehensive care plan goals were sent to the receiving provider for Resident #43's facility initiated hospital transfer dated, 12/1/18. ASM #2, replied "No, because the nurses have not sent the care plans consistently." On 1/17/18 at approximately 10:51 a.m., ASM #1, the Administrator, ASM #2, the Director of Nursing and ASM #3, the nurse consultant were made aware of the findings. No further information was provided prior to exit.	F 622		

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F 622	Continued From page 5 1. Dementia with Lewy bodies, sometimes called Lewy body dementia, is one of a group of brain disorders called "dementia." This group of brain disorders causes memory problems and makes it hard to think clearly. The cause of dementia with Lewy bodies (called "DLB" here) is not known. It gets its name from build-ups of protein in the brain called "Lewy bodies" that can be found on an autopsy (an exam that is done after death). Lewy bodies are also seen in the brains of people with Parkinson disease, which is a brain disorder that affects movement. In people with DLB, the Lewy bodies are more widely spread throughout the brain than in people with Parkinson disease. This information was obtained from the website: https://www.uptodate.com/contents/dementia-with-lewy-bodies-the-basics?search=lewy%20body%20dementia&topicRef=5087&source=related_link 2. Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes the heart to beat much faster than normal, and the upper and lower chambers of the heart do not work together. When this happens, the lower chambers do not fill completely or pump enough blood to the lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in the heart, which increases your risk of having a stroke or other complications. This information was obtained from the website: https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation 3. Pneumonitis (noo-moe-NIE-tis) is a general term that refers to inflammation of lung tissue. Technically, pneumonia is a type of pneumonitis because the infection causes inflammation.	F 622		

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F 622	Continued From page 6 Pneumonitis, however, is usually used by doctors to refer to noninfectious causes of lung inflammation. Common causes of pneumonitis include airborne irritants at your job or from your hobbies. In addition, some types of cancer treatments and dozens of drugs can cause pneumonitis. Difficulty breathing - often accompanied by a dry (nonproductive) cough - is the most common symptom of pneumonitis. Specialized tests are necessary to make a diagnosis. Treatment focuses on avoiding irritants and reducing inflammation. This information was obtained from the website: https://www.mayoclinic.org/diseasesconditions/pneumonitis/symptoms-causes/syc-20352623?p=1 4. Parkinson's Disease: A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.	F 622		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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:	F 880	F 880 Infection: Prevention and Control Cross Reference with 12VACS-371-340(A) 1.No residents had no adverse effects 2.All residents receiving care have the potential to be affected. 3. The ice machine air gap was corrected immediately. 4. The facility will institute a new process to assure that the ice machine has an air gap. A. Ice machine gap will be checked on a monthly Basis and documented in a monthly log. B. Education will be provided to all dietary staff on the new process. 5. In order to assure on going compliance the facility will conduct a random audit of the air gap, this audit will be conducted weekly X weeks and monthly X 4 months. 6. All findings will be submitted to QA for review and recommendations. 7. The corrective action will be completed by February 15, 2019.	

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F 880	Continued From page 7 §483.80(a)(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 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(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 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 8 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, the facility staff failed to properly maintain an ice machine in a manner to prevent the spread of disease for one of four facility ice machines. The main kitchen ice machine did not have an air gap for the meltwater drain. The findings included: A tour of the facility kitchen was conducted on 01/29/19 at 11:45a.m. During the tour, it was noted that the main kitchen ice machine had a meltwater drain protruding below the front of the machine, over a grate covered floor drain. Upon close inspection, the mouth of the pipe coming from the ice machine was in direct contact with the grate of the floor drain. On 01/30/19, the ASM (Administrative Staff Member) #1, the Facility Administrator, was made aware of the concerns regarding the ice machine. ASM #1 stated that the problem would be fixed immediately. On the morning of 01/31/2019, at approximately	F 880		

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F 880	Continued From page 9 9:00am, ASM #1 informed this surveyor that the ice machine drain had been altered to have an air gap. Inspection of the ice machine confirmed an air gap was now in place. The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 01/31/19. No further documentation was provided.	F 880		

State of Virginia

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 1/29/19 through 1/31/19. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey. The census in this 49 licensed bed facility was 47 at the time of the survey. The survey sample consisted of 22 resident reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5 - 371 - 140 E 3b. Based on staff interview, facility document review, and employee record review, it was determined the facility staff failed to obtain criminal background checks within 30 days of hire, for three of 20 employee records reviewed, LPN (licensed practical nurse) #1, LPN #2 and CNA(certified nursing assistant) #1. 1. The facility staff failed to obtain the criminal background check within 30 days of hire for LPN #1. 2. The facility staff failed to obtain the criminal background check within 30 days of hire for LPN #2. 3. The facility staff failed to obtain the criminal background check within 30 days of hire for CNA #1.	F 001	12 VAC 5-371-140 E3b – The Facility will obtain criminal Background checks within 30 days of hire 1.No residents were adversely affected. 2.All residents receiving care have the potential to be affected. 3. The facility will conduct an audit of all new hires since January 1, 2018 to assure they had a criminal background check completed Within 30 days of hire, if not corrective measures will be taken. 4. The facility will institute a new process to assure all new hires have a criminal background check completed within 3o days of hire. A. New Hire Check list has been revised. B. A reminder will be set up to assure the criminal background check has been completed within 30 days of the hire/orientation date. C. The HR director will check and initial the date criminal background checks are received and reviewed. D. Education will be provided to all HR staff on the new process. 5. In order to assure on going compliance the facility will conduct an audit for all new hires to assure background check was completed within 30 days of hire this audit will be conducted monthly X 4 months. 6. All findings will be submitted to QA for review and recommendation. 7. The corrective action will be completed by February 15, 2019.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert K. DeMaria — TITLE: ADMINISTRATOR — (X6) DATE: 02/08/2019

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F 001	Continued From page 1 The findings include: 1. The facility staff failed to obtain the criminal background check within 30 days of hire for LPN #1. The employee record was reviewed for LPN #1. LPN #1's criminal background check was completed on 9/4/18. LPN #1's hire date was 10/17/18. An interview was conducted with other staff member (OSM) #1, the director of human resources, on 1/30/19 at 1:52 p.m. When asked how soon within employment should the criminal background checks be completed, OSM #1 stated, "Within 30 days." When asked why LPN was #1's criminal background check was completed 73 days prior to hire, OSM #1 stated, "She was offered the job on 10/4/18, she accepted the position on 10/7/18 and started on 10/17/18. 2. The facility staff failed to obtain the criminal background check within 30 days of hire for LPN #2. The employee record was reviewed for LPN #2. LPN #2's criminal background check was completed on 5/10/18. An interview was conducted with other staff member (OSM) #1, the director of human resources, on 1/30/19 at 1:52 p.m. When asked why LPN #2's criminal background check completed, 40 days prior to hire, OSM #1 stated, "She was interviewed on 5/10/18. She was offered the job on 5/30/18 and worked another job so she had to give two-week notice so she started on 6/20/18.	F 001		

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F 001	Continued From page 2	F 001		

3. The facility staff failed to obtain the criminal background check within 30 days of hire for CNA #1.

The employee record was reviewed for CNA #1. CNA #1's criminal background check was completed on 8/31/18. An interview was conducted with other staff member (OSM) #1, the director of human resources, on 1/30/19 at 1:52 p.m. When asked why CNA #1's criminal background check was completed 33 days prior to hire, OSM #1 stated, "She was offered the job on 9/18/18 and accepted the position. She was scheduled for orientation on 9/26/18. She could not attend orientation on that day and then started on 10/3/18.

The facility policy, "Abuse" documented in part, "Prevention: c. Criminal records checks will be obtained in accordance with state law and/or facility policy."

ASM (administrative staff member) #1, the administrator, was made aware of the above findings on 1/30/19 at 4:15 p.m.

No further information was obtained prior to exit.

12VAC5-371-340. Dietary and Food Service Program

12VAC5-371-340(A) cross reference to F880