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 _____	03/12/2020

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 3/10/20 through 3/12/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No/# complaint(s) was/were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 3/10/2020 through 3/12/2020. Significant 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 48 at the time of the survey. The survey sample consisted of 23 current record reviews and four closed record reviews.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to promote dignity for one of 27 residents in the survey	F 557	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in	4/20/20

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

Electronically Signed | 04/01/2020

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 _____	03/12/2020

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
F 557	Continued From page 1 sample with an indwelling catheter, (Resident #95). The Foley collection bag for Resident #95's Foley catheter was observed uncovered with urine visible in the bag during separate observations conducted. The findings include: Resident #95 was admitted to the facility on 3/6/2020 with diagnoses that include but were not limited to: acute pyelonephritis, [an infection, usually bacterial, of the kidney (1)], functional quadriplegia [paralysis affecting all four limbs and the trunk of the body below the level of spinal cord injury. Trauma is the usual cause (2)] and multiple sclerosis [a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover (3)]. There was no completed MDS (minimum data set) assessment at the time of the survey. The nursing admission assessment dated 3/6/2020 documented the resident was alert and oriented to place and able to make decisions. The nursing admission assessment documented the resident required extensive assistance with position changes and totally dependent with transfers. Observation was made of Resident #95 on 3/10/2020 at 2:20 p.m. The resident was in bed; an indwelling catheter collection bag was hanging off the side of the bed closest to the door. There was no cover over the bag and urine was visible in the bag. A second observation was made on 3/11/2020 at 9:05 a.m. of Resident #95 in bed with an indwelling catheter collection bag hanging off the side of the bed closest to the door. There was no cover on the bag and urine was visible in the Foley bag.	F 557	compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F557 It is the practice of the facility to ensure that all residents are treated with respect and dignity. I Corrective Action Residents #95 continues to have an indwelling catheter and the collection bag is now placed inside a privacy bag at all times. II Identification All residents residing in the facility with indwelling catheters have the potential to be affected by the alleged deficient practice. The Director of Nursing (DON)	

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 _____	03/12/2020

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
F 557	Continued From page 2 The baseline care plan date 3/8/2020 documented in part, "Problem/Area of Concern: Resident has indwelling catheter - supra pubic." The "Interventions/Approaches" documented in part, "Provide catheter care per order/facility policy. Report change in urinary output." An interview was conducted with LPN (licensed practical nurse) #1 on 3/11/2020 at 2:08 p.m., regarding the process staff follows for maintaining the collection bags for residents' with an indwelling catheter. LPN #1 stated if it [Foley catheter and collection bag] is attached to the resident, it has to have a privacy bag with it. When asked why there is a privacy bag, LPN #1 stated for privacy and to maintain dignity as well." The facility policy, "Indwelling Urinary Catheter Maintenance" documented in part, "Place indwelling catheter drainage bag in privacy bag at all times." ASM (administrative staff member) #1, the administrator, and ASM #2 were made aware of the above concern on 3/11/2020 at 5:50 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 487. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 489. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380.	F 557	or designee has completed an audit of indwelling catheters and ensured all Foley collection bags are inside privacy bags. III Systemic Changes The DON or designee will train the nursing staff regarding the dignity of residents as it relates to keeping Foley collection bags in a privacy bag at all times. IV Monitoring The DON or designee will audit compliance of keeping Foley collection bags covered inside privacy bags weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. V Date of Compliance 4/20/2020	

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 _____	03/12/2020

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
F 655	Continued From page 3	F 655		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident.	F 655		4/20/20

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 _____	03/12/2020

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
F 655	Continued From page 4 (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. 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 ensure the base line care plan included all the healthcare information necessary to properly care for one of 27 residents in the survey sample, Resident #95. The facility staff failed to ensure the base line care plan for Resident #95 addressed the residents Midline Catheter, care and failed to update the base line care plan when heparin was ordered for Resident #95. The findings include: Resident #95 was admitted to the facility on 3/6/2020 with diagnoses that include but were not limited to: Acute pyelonephritis [an infection, usually bacterial, of the kidney (1)], functional quadriplegia [paralysis affecting all four limbs and the trunk of the body below the level of spinal cord injury. Trauma is the usual cause (2)] and multiple sclerosis [a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover (3)]. There was no completed MDS (minimum data set) assessment at the time of the survey. The nursing admission assessment dated 3/6/2020 documented the resident was alert and oriented to place and able to make decisions. The nursing	F 655	F655 It is the practice of the facility to develop and implement a baseline care plan for each resident I Corrective Action The care plan for Resident #95 has been updated to include the midline care and heparin use. The order for midline use and heparin has also been discontinued. II Identification All residents currently living in the facility have the potential to be affected by the deficient practice. The DON or designee will complete an audit of baseline care plans for residents admitted in the last seven (7) days for completeness as required. III Systematic Changes	

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 _____	03/12/2020

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
F 655	Continued From page 5 admission assessment documented the resident required extensive assistance with position changes and totally dependent with transfers. The baseline care plan was reviewed on 3/10/2020 at 2:25 p.m. The baseline care plan dated 3/8/2020, failed to evidence documentation that the resident had a Midline Catheter [vascular access devices often referred to as ' middle ground ' intravenous catheters. Like peripherally inserted central catheters (PICCs), midlines are inserted in the peripheral veins of the upper extremity; however, unlike PICCs, midlines terminate in the peripheral, not the central veins.] (4) The physician orders dated, 3/7/2020 documented, "Midline Catheter: change site dressing with transparent dressing, change catheter securement device, measure upper arm circumference and measure external catheter length every week." The physician order dated, 3/9/2020 documented, "Heparin 5,000 unit/ml (units per milliliters) injection solution - 1 vial subcutaneous every 12 hours x 4 weeks or until discharge for DVT (deep vein thrombosis)." An interview was conducted with LPN (licensed practical nurse) #1, on 3/11/2020 at 2:04 p.m., regarding the baseline care plan for a resident with a midline catheter. LPN #1 stated it [midline catheter] should be there. The order for heparin was reviewed with LPN #1. When asked if the heparin should be care planned, LPN #1 stated, yes it should be on the care plan. It increases the resident's risk for bleeding. The facility policy, "Comprehensive Person-Centered Care Planning" documented in	F 655	The DON or designee will educate the clinical nursing staff in the area of capturing all the healthcare information necessary to properly care for residents. IV Monitoring The DON or designee will audit five resident□s clinical records weekly for four weeks and monthly for two months to ensure compliance of care plans capture of all necessary health care information to properly care for our residents. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. V Date of Compliance 4/20/2020	

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 _____	03/12/2020

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
F 655	Continued From page 6	F 655		

part, "A preliminary (interim) care plan to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. 1. To assure that the resident's immediate care needs are met and maintained, an interim care plan will be developed within 48 hours of the resident's admission. a) The interdisciplinary team will review the following to assist in developing the interim care plan: orders obtained at the time of admission. IDT (interdisciplinary team) initial evaluations and assessment...b) The interim care plan will be used while the comprehensive admission MDS assessment and CAA (care area assessment) review is being conducted. c) The interim care plan will form the foundation of the comprehensive care plan and be incorporated as the comprehensive care plan is developed."

ASM (administrative staff member) #1, the administrator, and ASM #2 were made aware of the above concern on 3/11/2020 at 5:50 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 487.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 489.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380.
(4) Midline catheters are unique vascular access devices often referred to as ' middle ground ' intravenous catheters. Like peripherally inserted central catheters (PICCs), midlines are inserted in the peripheral veins of the upper extremity;

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 _____	03/12/2020

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
F 655	Continued From page 7 however, unlike PICCs, midlines terminate in the peripheral, not the central veins. By definition, the tip of the midline catheter should be located at or near the level of the axilla, distal to the shoulder. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6860966/	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		4/20/20

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 _____	03/12/2020

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
F 656	Continued From page 8 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. 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 develop and/or implement the comprehensive care plan for four of twenty seven residents in the survey sample, Resident #6, #10, #94 and #18. The facility staff failed to develop a comprehensive care plan to address the use of side rails for Resident #6, Resident #10, and Resident #18, and failed to develop a comprehensive care plan to address Resident #94's use of a spirometer and failed to implement Resident #94's comprehensive care plan for the administration of oxygen. The findings include: 1. Resident #6 was admitted to the facility on 11/13/19 with diagnoses that included but were not limited to: end stage renal disease (ESRD) [final stage of irreversible kidney disease. (1)], coronary artery disease, [plaque forming on the inner walls of the arteries of the heart] (2), and atrial fibrillation [rapid/random contractions of the upper chambers of the heart]. (3)	F 656	F 656 It is the practice of this facility to develop a comprehensive person-centered care plan for each resident 1. Correction The care plans for residents #6, #10, and #18 have been updated to include the use of side rails. Resident #94 no longer has an order for the use of a spirometer. Resident #94 has a signed consent form now in her medical records for the use of side rails. Resident #18 now receives oxygen set at 3 Liters to reflect physician□s order, and the resident did not have any adverse effect from receiving the lower oxygen liters. II Identification	

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 _____	03/12/2020

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
F 656	Continued From page 9 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/13/20, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively moderately impaired. The resident was coded as requiring extensive assistance for bed mobility. Resident #6 was observed in bed with bilateral upper side rails raised on 3/10/20 11:44 AM and 3/10/20 at 4:24 PM. A review of Resident #6's comprehensive care plan documented in part, The Focus: dated 11/13/19 "Impaired ADLs (activities of daily living) related to weakness, dementia and ESRD." The Interventions: dated 11/13/19 "Call bell within reach, use of sling lift with two staff assist, keep assistive devices within easy access for resident/caregiver use: wheelchair." The comprehensive care plan did not include the use of side rails under any focus area. A review of the physician orders dated 11/13/19, documented in part the following, "May use two upper 1/4 side rails while in bed to assist resident with bed mobility and transfers while maintaining or obtaining their highest practicable level of physical care and to ensure resident's safety." An interview was conducted with Resident #6 on 3/10/20 at 4:24 PM. When asked if he used the side rails, Resident #6 stated, "Yes, I use them to turn in bed and in getting in bed as a guide." An interview was conducted with on 3/10/20 at 5:04 PM with LPN (licensed practical nurse) #2, the LPN charge nurse. When asked the purpose	F 656	All residents have the potential to be affected by these deficient practices. 1. The interdisciplinary team will conduct an audit of all residents with side rails for inclusion in their care plans, and for the presence of informed consent for side rail use. 2. The interdisciplinary team has audited all the residents on oxygen to match their physician orders with oxygen settings on the concentrators for accuracy. No further discrepancy noted. 3. There is no resident using a spirometer at this time. III System change 1. The DON or designee will reeducate licensed clinical staff on the complete process of side rail plan and procedures, including consent signing. 2. The DON or designee will reeducate clinical staff, including the MDS coordinator on the development and implementation of a comprehensive patient-centered plans of care. 3. Members of the interdisciplinary team, including administrator will continue to observe oxygen settings for correctness during random walking rounds. 5. Every new physician□s order for side rail use will be reviewed by the	

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 _____	03/12/2020

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
F 656	Continued From page 10 of the care plan, LPN #2 stated, "It is to document the identified care needed for each resident." When asked if the use of side rails should be part of the care plan, LPN #2 stated, "Yes, they should be." An interview was conducted on 3/11/20 at 3:00 PM with RN (registered nurse) #1, the MDS coordinator. When asked who updates the care plan, RN #1 stated, "I update the comprehensive care plan through the interdisciplinary team. I ask the CNA (certified nursing assistant) to attend the meeting, and if they are busy, I ask them to give me any information." When asked if the sue of side rails ordered by the physician should be part of the care plan, RN #1 stated, "Yes, I look at physician orders and that determines the potential focus areas and actions." On 3/11/20 at 5:30 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were informed of the above concern. The facility's "Comprehensive Person-Centered Care Planning" policy revised 1/2020, documents in part, "The comprehensive care plan shall be developed by a Care Planning/Interdisciplinary Team based on orders obtained at admission. The comprehensive care plan will promote patient safety." The facility's "Bed Entrapment Assessment" policy revised 1/2020, documents in part, "The reason for the side rails and their proper use will be integrated into the comprehensive care plan and revised as necessary." No further information was provided prior to exit.	F 656	administrator or designee for completeness, including a signed inform consent. IV Monitoring In order to ensure ongoing compliance, the DON or designee will conduct random audits of five care plans for completeness, five residents oxygen settings for correctness, and all new side rails orders for consent signing weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. V. Date of Compliance 4/20/2020	

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 _____	03/12/2020

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
F 656	Continued From page 11	F 656		

References:
1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 498.
2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 52.
3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 54.

2. Resident #10 was admitted to the facility on 11/25/19; diagnoses include but are not limited to: intra-vertebral disc lumbar region [cushioning tissue between the bony column of the lumbar region of the spine] (1), coronary artery disease [plaque forming on the inner walls of the arteries of the heart] (2) and atrial fibrillation [rapid/random contractions of the upper chambers of the heart]. (3)

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/27/20, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. The resident was coded as requiring extensive assistance for dressing, bathing and toilet use; limited assistance for bed mobility.

Resident #10 was observed in bed with bilateral upper side rails raised on 3/10/20 4:04 PM and 3/11/20 at 9:30 AM.

A review of Resident #10's comprehensive care plan documented in part, The Focus: dated 11/25/19 "Impaired ADLs (activities of daily living) related to thoracic vertebra 12/ post kyphoplasty [surgical filing of collapsed vertebra to restore

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 _____	03/12/2020

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
F 656	Continued From page 12	F 656		

original shape and configuration]." The Interventions: dated 11/25/19 "Provide assistance with ADL functioning as indicated. Report changes in resident function to nurse. Report immobility complications to physician." The comprehensive care plan did not include use of side rails under any focus area.

A review of the physician orders dated 11/25/19, documents in part, "May use two upper 1/4 side rails while in bed to assist resident with bed mobility and transfers while maintaining or obtaining their highest practicable level of physical care and to ensure resident's safety."

An interview was conducted with Resident #10 on 3/10/20 at 4:04 PM. When asked if he used the side rails, Resident #10 stated, "Oh, yes, I use them to help getting in and out of the bed. When I am in the bed, they give me something to use to turn."

An interview was conducted with on 3/10/20 at 5:04 PM with LPN (licensed practical nurse) #2, the LPN charge nurse. When asked the purpose of the care plan, LPN #2 stated, "It is to document the identified care needed for each resident." When asked if side rails should be part of the care plan, LPN #2 stated, "Yes, they should be."

An interview was conducted on 3/11/20 at 3:00 PM with RN (registered nurse) #1, the MDS coordinator. When asked who updates the care plan, RN #1 stated, "I update the comprehensive care plan through the interdisciplinary team. I ask the CNA (certified nursing assistant) to attend the meeting, and if they are busy, I ask them to give me any information." When asked if a physician orders side rails should they be part of the care

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 _____	03/12/2020

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
F 656	Continued From page 13	F 656		

plan, RN #1 stated, "Yes, I look at physician orders and that determines the potential focus areas and actions."

On 3/11/20 at 5:30 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were informed of the above concern.

No further information was provided prior to exit.

References:
1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 167/341.
2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 52.
3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 54.
3. a. Resident #94 was admitted to the facility on 2/25/2020 with diagnoses that included but were not limited to: osteomyelitis, [a infection of bone and bone marrow usually caused by bacteria. (1)], high blood pressure, and gastroesophageal reflux disease, [the backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn]. (2)

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/29/2020 coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living

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 _____	03/12/2020

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
F 656	Continued From page 14	F 656		

except eating in which she was coded as requiring supervision after set up assistance was provided.

The review of the comprehensive care plan dated 3/1/2020 failed to evidence the use of a spirometer.

Observation and interview was conducted on 3/10/2020 at 11:45 a.m. Resident #94 was in bed and a spirometer was observed on the nightstand. The spirometer was not covered. When asked if she uses the spirometer, Resident #94 stated she should be using it, it came from the hospital with her. She stated she was using it when she first came to the facility.

Review of the clinical record failed to evidence a physician order for the use of a spirometer.

An interview was conducted with LPN (licensed practical nurse) #1, on 3/11/2020 at 1:47 p.m. When asked who develops the care plan for the use of a spirometer, LPN #1 stated the MDS nurse does it all the time.

An interview was conducted with RN (registered nurse) #1, the MDS nurse, on 3/11/2020 at 2:54 p.m. When asked who updates the care plans, RN #1 stated, mainly me. The baseline care plan is to be started by the supervisor or the admitting nurse.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 3/11/2020 at 2:58 p.m. When asked who updates resident care plans, ASM #2 stated, "I expect the nurse's to update the care plan as needed."

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 _____	03/12/2020

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
F 656	Continued From page 15 ASM (administrative staff member) #1, the administrator, and ASM #2 were made aware of the above concern on 3/11/2020 at 5:50 p.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 423. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. 3. b. Review of the comprehensive care plan dated 3/1/2020, failed to evidence the use of the side rails. Resident #94 was observed in her bed on 3/10/2020 at 11:45 a.m. and on 3/11/2020 at 9:00 a.m. During both observations, the resident was in bed with bilateral side rails up. When asked if she uses them, Resident #94 stated that they help her move in the bed. Review of the clinical record failed to evidence a consent signed for the use of the side rails. An interview was conducted with RN (registered nurse) #1 on 3/11/2020 at 3:33 p.m. When asked if the use of side rails should be on the care plan, RN #1 stated she care plans them if they have an order for them. She doesn't usually care plan something without a physician order. The facility policy, Bed Entrapment Assessment documented in part, "The reason for the side rails and their proper use will be integrated into the comprehensive care plan and revised as necessary.	F 656		

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 _____	03/12/2020

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
F 656	Continued From page 16 ASM (administrative staff member) #1, the administrator, and ASM #2 were made aware of the above concern on 3/11/2020 at 5:50 p.m. No further information was provided prior to exit 4. Resident #18 was admitted to the facility on 8/29/17 with diagnoses that included but are not limited to: Alzheimer's disease (a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability.) (1), high blood pressure, and gastroesophageal reflux disease GERD (backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn). (2) The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/19/2020 coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was not coded as using oxygen. The comprehensive care plan dated, 9/25/19, documented in part, "Category: Pulmonary - Monitor Oxygen saturation and administer oxygen per physician orders." Observation was made of Resident # 18 on	F 656		

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 _____	03/12/2020

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
F 656	Continued From page 17	F 656		

3/20/2020 at 12:35 p.m. during the initial tour. The resident was in bed with her oxygen on via a nasal cannula (a two-pronged tube that inserts into the nose). The oxygen concentrator was set at 2LPM (liters per minute). A second observation was made on 3/11/2020 at 10:15 a.m. The resident was again in bed with her oxygen on at 2LPM.

The physician order dated, 2/24/2020 documented, "O2 (oxygen) @ (at) 3 lit (liters) via N/C (nasal cannula) - every day as needed for SOB (shortness of breath)."

On 3/11/2020 at 3:51 p.m., LPN (licensed practical nurse) # 4 went to Resident #18's room. When asked to state the oxygen flow rate, LPN #4 stated it was at 2 LPM. LPN #4 was asked to review the resident's physician order for oxygen. LPN #4 stated it documents, 3 LPM. When asked the purpose of the care plan, LPN #4 stated its how we know more about the resident and what care we are to provide to them. When asked if the care plan was implemented if it documents to administer oxygen as ordered, and the resident is not receiving the prescribed flow rate of oxygen, LPN #4 stated, "No, Ma'am."

ASM (administrative staff member) #1, the administrator, and ASM #2 were made aware of the above concern on 3/11/2020 at 5:50 p.m.

No further information was obtained prior to exit.

References:
(1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

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 _____	03/12/2020

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
F 656	Continued From page 18 Chapman, page 243.	F 656		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide the necessary care and services to prevent pressure ulcer development and promote healing for one of 27 residents in the survey sample, (Resident #11). The facility staff, failed to identify, obtain and provide treatment for a sacral pressure injury prior to the wound, being found at an advanced stage, resulting in harm. On 2/16/2020, CNA (certified nursing assistant) #1, documented a new area was identified on Resident #11's sacrum and notified the nurse. Staff did not complete an assessment of the area, until 2/19/2020, and documented a sacral wound was present with redness and eschar [a scab or crust that forms on the skin]. Measurements and treatment for the wound were not provided until	F 686	F 686 It is the practice of this facility to provide the necessary care and services to prevent pressure ulcer development and promote healing for its residents. I Correction 1. Resident #11 now has her sacral wound assessed weekly, including measurements and treatment as ordered by the physician 2. The sacral wound is currently documented as improving. 3. A wound protocol is now in place at the facility.	4/20/20

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 _____	03/12/2020

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
F 686	Continued From page 19 2/20/2020, at which time the wound care physician documented the sacral area as an unstageable (due to necrosis) pressure injury, measuring 2.4 x 4.5 x 0.1 cm (centimeters), with thick adherent devitalized necrotic tissue in 70% of the wound, and 30% granulation tissue The findings include: Resident #11 was admitted to the facility on 2/11/2020 with diagnoses that included but were not limited to: high blood pressure, diabetes, a fracture of the pelvic bone and Alzheimer's disease [a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability]. (1) The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/2/2020 coded the resident as scoring a "2" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Resident #11 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. In Section M - Skin Conditions, the resident was coded as having an unstageable pressure injury. A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear	F 686	II Identification All residents have the potential to be affected by this deficient practice. III System changes The DON or designee will conduct mandatory education to the nursing staff, including licensed clinical staff and nursing assistants on the identification of skin alterations and timely intervention. The nursing staff will also be reeducated on the new facility wound protocol. IV Monitoring In order to ensure ongoing compliance, the facility will conduct random audits of 4 residents weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. V Date of Compliance 4/20/2020	

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 _____	03/12/2020

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
F 686	Continued From page 20	F 686		

may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (2).

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed (3).

On admission on 2/11/2020, the admission assessment failed to evidence documentation of any pressure injury. The admission assessment only documented the presence of bruising in multiple areas of the body, but not the sacrum. A nursing assessment dated 2/11/2020 documented a check mark next to "Skin intact."

The Braden Scale for Predicting Pressure Sore Risk dated 2/11/2020 documented Resident #11 had scored a "12," indicating the resident was at risk for pressure ulcer development. The form documented, "If the residents total is 12 or less, consider him/her at risk for pressure ulcer development."

The CNA daily charting dated 2/16/2020 documented, "Description: Skin Condition - Resident shows evidence of new skin problem? Yes, was documented under status/description. Skin Condition you must notify nurse. Check if nurse notified. A check mark was documented in the box.

Review of the nurse's notes failed to evidence documentation regarding the new skin problem

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 _____	03/12/2020

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
F 686	Continued From page 21	F 686		

until 2/19/2020.

A nurse's note dated, 2/19/2020 at 11:00 a.m. documented in part, "Writer noted patient to have a wound on her sacrum with redness and eschar [a scab or crust that forms on the skin (4)] on 12 o'clock, pt (patient) denied pain on the area."

The wound care, specialist note, dated 2/20/2020, documented the wound as an unstageable (due to necrosis) on sacrum. The 2/20/2020 not documented the wound measured 2.4 x 4.5 x 0.1 cm (centimeters), and was documented as thick adherent devitalized necrotic tissue in 70 % of the wound with 30% granulation tissue. The wound doctor did debridement on the wound to a depth of 1.4 cm.

Review of the physician orders dated, 2/21/2020, revealed a physician order for Santyl topical ointment [promotes debridement of necrotic tissue in dermal ulcers] (5) - 1 ribbon topical every day cleanse wound on Sacral area with NSS [normal saline solution], pat dry and apply Santyl daily and cover with foam dressing. For Unstageable necrosis."

Review of the February TAR documented the above physicians order for Santyl. The first documentation of the medication was on 2/21/2020.

The comprehensive care plan dated 2/11/2020 documented in part, Category: Pressure Ulcers: Actual and at risk for skin breakdown due to incontinence and impaired mobility...Left buttock 2/20/2020 pressure injury sacrum. A (approach) encourage and assist with turning and repositioning. Assist with toileting as needed.

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 _____	03/12/2020

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
F 686	Continued From page 22	F 686		

Skin assessment every week per protocol. Apply moisturizer/lotion to skin as needed. Use of pressure reducing mattress. Nutritional supplements as ordered. Labs (laboratory tests) as ordered, monitor nutrition related lab results."

An interview was conducted with CNA # 1 on 3/12/2020 at 10:30 a.m. When asked if she routinely worked with Resident #11, CNA #1 stated that is her normal assignment. CNA #1 was asked if 2/16/2020 was it the first time she saw something on the resident's sacrum. CNA #1 stated she had been off for a few days and when she was assisting the resident to the restroom, she found this black area (on the resident's sacrum). CNA #1 stated the area was the size of a dime, and it was hard to see as it was in the crack of the buttock. CNA #1 stated she had to separate the buttocks to see the area. CNA #1 stated she notified the nurse. When asked what the nurse did, CNA #1 stated she didn't know what she (the nurse) did; she was not the normal nurse that works on the unit. When asked if she had documented the area she found, CNA #1 stated she documented it in the ADL (activities of daily living) records. When asked how often she looks at the resident's skin, CNA #1 stated on shower days, twice a week. We also look at the bottoms when we change them. We do it twice a week with the nurse.

An interview was conducted RN (registered nurse) #2, the supervisor, on 3/12/2020 at 12:09 p.m., regarding when she was made aware of the area on Resident #11's buttock. RN #2 stated the aide (CNA #1) was taking her to the bathroom and said I needed to look at it. When asked about the date she saw the area, it, RN #2 stated she was a floor nurse on 2/19/19. When asked what

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 _____	03/12/2020

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
F 686	Continued From page 23	F 686		

she observed, RN #2 stated that it (wound on Resident #11's sacrum) was necrotic, black at the 12 o'clock area, and it was not blanchable. RN #2 stated she called the wound care doctor. He was due be in the facility the next day. When asked if she put a treatment in place at that time, RN #2 stated, no she just put a protective dressing over it. When asked if she measured the sacral wound, RN #2 stated, no, because the wound doctor would be there the next day and he would measure it.

The wound was observed on 3/12/2020 at 10:30 a.m. with LPN (licensed practical nurse) #1. The wound was measured by LPN #1 and was found to be 4.5 cm in length, 3.5 cm in width and 4.2 cm in depth. There was noted slough and necrotic tissue inside the wound. The edges of the wound appeared to have some maceration.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/12/2020 at 12:26 p.m. When asked about the process staff follows for resident skin assessments, ASM #2 stated currently, the process in place is for weekly skin assessments during showers. When asked if staff document these assessments, ASM #2 stated that the nurse is to document on the TAR. ASM #2 was asked about the process staff follows, if something is found during the assessment. ASM #2 stated they document it on a skin assessment tool in the computer. When asked about the process followed if a CNA finds something, ASM #2 stated the CNAs documents it in POC (point of care - computer program) and notify the nurse. The nurse is to then follow up with the information, look at it, assess it and notify the doctor and RP (responsible party). When asked

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 _____	03/12/2020

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
F 686	Continued From page 24	F 686		

about the nurse who was on duty on 2/16/2020, ASM #2 stated she was an as needed nurse and was unavailable for interview. ASM #2 was informed of the concern, and ASM #2 was asked if she had anything further to present. ASM #2 stated that she had the same information and nothing more.

ASM #1, the administrator, and ASM #2 were made aware of the concern for harm related to the delay in treatment of a pressure injury on 3/12/2020 at 1:03 p.m.

An interview was conducted with the wound care doctor, ASM # 3 on 3/12/2020. When asked if it is his practice not to give treatment orders when the staff notifies him of a pressure injury, ASM #3 stated he would not prescribe anything until he examines the area. When asked if the facility has, a protocol to use for wounds identified in between his visits, ASM #3 stated he was not sure. ASM #3 stated that he had seen the wound on 3/12/2020 and felt the wound had improved.

On 3/12/2020 at 2:58 p.m., ASM #2 was asked if they had a wound protocol, they follow; ASM #2 stated they did not have a wound protocol at the time of the resident's wound.

No further information was presented prior to exit.

(1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26.
(2) This information was obtained from the following website: https://cdn.ymaws.com/npuap.sitem.com/resource/resmgr/npuap_pressure_injury_stages.pdf.
(3) This information was obtained from the following website:

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 _____	03/12/2020

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
F 686	Continued From page 25 https://cdn.ymaws.com/npuap.sitem.com/resource/resmgr/npuap_pressure_injury_stages.pdf. (4) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 207. (5) This information was obtained from the following website: Lexi-Comp's Drug Reference Handbooks: Drug Information Handbook for Nursing: 8th Edition 2007 pg. 301	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory care and services for two of 27 residents in the survey sample, Residents #18 and #94. The facility staff failed to administer oxygen to Resident #18 according to the physician's order and staff failed to obtain an order for Resident #94's use of a spirometer. The findings include: 1. Resident #18 was admitted to the facility on 8/29/17 with diagnoses include but are not limited to: Alzheimer's disease [a progressive loss of mental ability and function, often accompanied by	F 695	F695 It is the practice of this facility to provide respiratory care and services for its residents. I Correction 1. Resident #18 now has her oxygen setting at 3 liters as ordered by the physician. 2. Resident #94 no longer has an order for the use of a spirometer.	4/20/20

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 _____	03/12/2020

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
F 695	Continued From page 26 personality changes and emotional instability.] (1), high blood pressure, and gastroesophageal reflux disease GERD [a backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn]. (2) The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/19/2020 coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was not coded as using oxygen. Observation was made of Resident # 18 on 3/20/2020 at 12:35 p.m. during the initial tour. The resident was in bed with her oxygen on via a nasal cannula (a two-pronged tube that inserts into the nose). The oxygen concentrator was set at 2LPM (liters per minute). A second observation was made on 3/11/2020 at 10:15 a.m. The resident was again in bed with her oxygen on at 2LPM. The physician order dated, 2/24/2020 documented, "O2 (oxygen) @ (at) 3 lit (liters) via N/C (nasal cannula) - every day as needed for SOB (shortness of breath)." The Treatment Administration Record for March 2020 documented the above order. There was no	F 695	II Identification All residents have the potential to be affected by this deficient practice. All residents with oxygen orders have had their physician□s orders reviewed and ordered settings matched with settings at the bedside. III System changes The DON or designee will conduct an in-service on physician□s orders regarding respiratory care and services, including oxygen settings and spirometer use. IV Monitoring In order to ensure ongoing compliance, the facility will conduct random audits of 4 residents weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.	

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 _____	03/12/2020

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
F 695	Continued From page 27 documentation related to the use of the oxygen. The comprehensive care plan dated, 9/25/19, documented in part, "Category: Pulmonary - Monitor Oxygen saturation and administer oxygen per physician orders." On 3/11/2020 at 3:51 p.m., LPN (licensed practical nurse) # 4 went to Resident #18's room. When asked to state the current oxygen flow rate, LPN #4 stated it was at 2 LPM. LPN #4 was asked to review the resident's physician order for oxygen. LPN #4 stated it documents, 3 LPM. When asked if the staff were following the physician's orders for the administration of oxygen to Resident #94, LPN #4 stated, no. The facility policy, "Oxygen Administration" documented in part, "Policy, It is the policy of (Name of facility) to administer supplemental oxygen per physician's order and when indicated in a medical emergency as per standing orders." ASM (administrative staff member) #1, the administrator, and ASM #2 were made aware of the above concern on 3/11/2020 at 5:50 p.m. No further information was obtained prior to exit. References: (1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. 2. Resident #94 was admitted to the facility on	F 695	V Date of Compliance 4/20/2020	

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 _____	03/12/2020

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
F 695	Continued From page 28	F 695		

2/25/2020 with diagnoses that included but were not limited to: osteomyelitis [an infection of bone and bone marrow usually caused by bacteria.] (1), high blood pressure, and gastroesophageal reflux disease [a backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn]. (2)

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/29/2020 coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was coded as requiring supervision after set up assistance was provided.

Observation was made of Resident #94's room on 3/10/2020 at 11:45 a.m. The resident was in bed and a spirometer was observed on the nightstand. The spirometer was not covered. When interviewed about the use of the spirometer, Resident #94 stated she should be using it; it came from the hospital with her. She stated she was using it when she first came to the facility.

Review of the clinical record failed to evidence a physician order for the use of a spirometer.

The review of the comprehensive care plan dated 3/1/2020 failed to evidence the use of a spirometer.

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 _____	03/12/2020

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
F 695	Continued From page 29 An interview was conducted with LPN (licensed practical nurse) #1, on 3/11/2020 at 1:47 p.m. When asked if there needs to be an order for the use of a spirometer, LPN #1 stated yes that it came from the hospital and it wasn't on her orders. When asked if there should be a physician order a spirometer is in the room, and the residents states they are using the spirometer, LPN #1 stated, we should have an order or get it discontinued. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 3/11/2020 at 5:50 p.m. A policy on the use of a spirometer was requested on 3/11/2020 at 5:50 p.m. On 3/12/2020 at approximately 11:15 a.m., ASM #2 stated they did not have a policy on the use of spirometers. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 423. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the	F 698		4/20/20

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 _____	03/12/2020

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
F 698	Continued From page 30 comprehensive person-centered care plan, and the residents' goals and preferences. 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 ensure dialysis services, were provided consistent with professional standards of practice, and the comprehensive person-centered care plan, for one of twenty-seven residents in the survey sample, Resident #6. The facility staff failed to communicate with the dialysis facility for Resident #6, during his Monday/Wednesday/Friday dialysis treatments. The findings include: Resident #6 was admitted to the facility on 11/13/19 with diagnoses that included but were not limited to: end stage renal disease (ESRD) (final stage of irreversible kidney disease) (1), coronary artery disease (plaque forming on the inner walls of the arteries of the heart) (2) and atrial fibrillation (rapid/random contractions of the upper chambers of the heart) (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/13/20, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively moderately impaired. In Section G (functional status)- the resident was coded as requiring extensive assistance for bed mobility, transfer, locomotion on/off the unit, dressing, toilet use and personal hygiene; dependent for bathing and supervision for eating. In Section O (special procedures) -	F 698	F 698 It is the practice of this facility to ensure that residents who require dialysis services are provided and are consistent with professional standards of practice, and the comprehensive person-centered care plan. 1. Correction Resident #6 now has a communication form in his dialysis book from the facility to the dialysis center. The form is being written on during his dialysis days, including resident□s thrill and bruit of access site. II Identification Residents receiving dialysis who reside at this facility have the potential for this deficient practice. Currently, the facility has only resident #6 as receiving dialysis services. III System Change The dialysis communication of resident #6 is being audited randomly every week for communication entries.	

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 _____	03/12/2020

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
F 698	Continued From page 31 the resident was coded as receiving dialysis while a resident. On 3/10/20 at 5:00 AM, Resident #6's dialysis communication book was reviewed. There were no communication forms from the facility to the dialysis (mechanical purification of the blood as a substitute for normal kidney function) center since the resident was admitted on 11/13/19. Resident #6 receives dialysis Monday/Wednesday/Friday dialysis treatments since 11/15/19 for a total of 50 dialysis visits. A review of the physician's orders dated 11/14/19 documented in part, "Dialysis on Monday, Wednesday and Friday from 10:00 AM to 3:00 PM." A review of Resident #6's comprehensive care plan documented in part, the Focus: dated 11/13/19 "Dialysis: receives hemodialysis every Monday, Wednesday and Friday 10:00 AM - 3:00 PM, has potential for complication." The Interventions: dated 11/13/19 "Assess thrill and bruit of access site on left upper arm each shift. If absent, notify the physician or dialysis nurse and document this information." An interview was conducted with on 3/10/20, at 5:04 PM with LPN (licensed practical nurse) #2, the LPN charge nurse. When asked the purpose of the dialysis communication book, LPN #2 stated, "It is for the dialysis center to provide us with information on the treatment and if there are any new orders." When asked if the facility communicated with the dialysis center, LPN #2 stated, "We only provide communication to the dialysis center if there is a change in medicines or status. We do not communicate with every visit.	F 698	IV Monitoring In order to ensure ongoing compliance, the facility will conduct random audits of the resident□s dialysis book for completed communication form weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. V Date of compliance 4/20/2020	

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 _____	03/12/2020

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
F 698	Continued From page 32	F 698		

They perform weights at the dialysis center." When asked if Resident #6's fistula was assessed for bruit and thrill, LPN #2 stated, "Yes, we check it every shift." When asked if that information was communicated in the dialysis book, LPN #2 stated, "No."

An interview was conducted on 3/11/20, at 3:15 PM with ASM (administrative staff member) #2, the director of nursing. When asked what communication is provided to the dialysis facility for Resident #6, ASM #2 stated, "We document more in the negative, for instance, if there has been a change in condition, new orders or labs [laboratory tests]. We do not send information if everything is the same." When asked if there is a policy, ASM #2, the director of nursing, stated, "Yes, I will get it to you."

On 3/11/20 at 5:30 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were informed of the above concern.

The facility's policy on "End-Stage Renal Disease, Care of a Resident with ESRD", documented in part, "Agreements between this facility and the contracted ERSD facility will include all aspects of how the resident's care will be managed, including: how the care plan will be developed/ implemented and how information will be exchanged between the facilities."

The facility's contract with the dialysis facility, documented in part, "Facility shall ensure that all appropriate medical, social, administrative, and other information accompany all designated residents at the time of transfer to the center. This information, shall include, but is not limited

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 _____	03/12/2020

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
F 698	Continued From page 33 to, where appropriate, the following: appropriate medical records, including history of the designated resident's illness, treatment presently being provided to the designated resident including medications, any changes in patient's condition and any other information that will facilitate the adequate coordination of care as reasonably determined by the center. No further information was provided prior to exit. References: 1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 498. 2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 52. 3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 54.	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions	F 700		4/20/20

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 _____	03/12/2020

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
F 700	Continued From page 34 are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to implement bed rail (side rail) requirements for one of 27 residents in the survey sample, Resident #94. The facility staff failed to obtain an informed consent prior to the use of side rails for Resident #94. The findings include: Resident #94 was admitted to the facility on 2/25/2020 with diagnoses that included but were not limited to: osteomyelitis [an infection of bone and bone marrow usually caused by bacteria.] (1), high blood pressure, and gastroesophageal reflux disease, [is the backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn]. (2) The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/29/2020 coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living	F 700	F 700 It is the practice of this facility to follow and implement bedrails requirements for its residents using bedrails in the facility. I Correction Resident #94 now has a a completed and signed consent form in her medical records. II Identification All residents using bedrails in the facility have the potential to be affected by this deficient practice. III System changes Facility will conduct re-education to all nursing staff on the bedrails implementation process, including assessment, physician□s orders, resident education, and informed consent signing. All residents currently using bed side rails	

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 _____	03/12/2020

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
F 700	Continued From page 35 except eating in which she was coded as requiring supervision after set up assistance was provided. Observation and an interview of Resident #94 was conducted on 3/10/2020, at 11:45 a.m. and again on 3/11/2020 at 9:00 a.m. During both observations, the resident was in bed with bilateral side rails up. When asked if she uses the side rails, Resident #94 stated that they help her move in the bed. Review of the clinical record failed to evidence a signed informed consent for the use of the side rails. Review of the comprehensive care plan dated 3/1/2020, failed to evidence the use of the side rails. An interview was conducted with LPN (licensed practical nurse) #1 on 3/11/2020 at 1:47 p.m. When asked about the process staff follows for the residents' use of side rails, LPN #1 stated they have to complete an assessment to see who needs them. They have to obtain a consent if the screening shows they need them [side rails]. LPN #1 was asked to review Resident #94's clinical record for a signed consent for the use of side rails. LPN #1 stated, no, we didn't do it. The facility policy, Bed Entrapment Assessment" documented in part, "c. If the resident's assessment identifies him or her as appropriate for the use of side rails, following procedures will be followed: i.) Educate the resident/resident representative on the risks and obtain consent for use."	F 700	in bed have had their medical records audited for the presence of signed consent forms. IV Monitoring In order to ensure ongoing compliance, the facility will conduct random audits of 4 residents with side rails weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. V Date of compliance 4/20/2020	

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 _____	03/12/2020

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
F 700	Continued From page 36 ASM (administrative staff member) #1, the administrator, and ASM #2 were made aware of the above concern on 3/11/2020 at 5:50 p.m. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 423. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.	F 700		
F 814 SS=B	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to dispose of refuse properly. The facility staff failed to maintain clean dumpster area during the facility task- kitchen observation 3/10/20 at 11:05 AM. The findings include: On 3/10/20 at 11:05 AM, an observation was conducted in the dumpster area outside of the main kitchen, with OSM (other staff member) #6, the director of dietary services. Two disposable gloves, paper trash and a cup were found around dumpster #1. No other trash found around other dumpsters and all dumpsters were closed. An interview was conducted on 3/10/20 at 11:20 AM, with OSM #6, the director of dietary services. When shown the trash outside of the dumpster,	F 814	F 814 It is the practice of this facility to dispose of refuse properly. I Correction The refuse, including the two disposable gloves, paper trash, and the cup found during survey rounds around dumpster #1 were cleared and disposed of immediately following notice by the surveyor. II Identification All residents have the potential to be affected by this deficient practice.	4/20/20

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 _____	03/12/2020

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
F 814	Continued From page 37 and asked who is responsible for maintaining the area, OSM #6 stated, "Maintenance is responsible for rounding out here and they round frequently and clean up any debris." When asked how long trash was outside dumpster, OSM #6 stated, "I don't know. They round very often out here." An interview was conducted on 3/11/20 at 12:30 PM with OSM #5, the director of facility and environmental services. When asked who is responsible for cleaning the dumpster area, OSM #5 stated, "We are responsible for cleaning the area." When asked how frequently area is checked, OSM #5 stated, "It is checked at least every shift." The facility's "Dumpster Policy and Procedures" dated 3/28/19, documented in part, "The environmental services department shall have the duty and responsibility for keeping the premises and buildings maintained in a safe, clean and attractive condition at all times. Absolutely no garbage will be deposited on the ground outside of the dumpster." On 3/11/20 at 5:30 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were informed of the above concern. No further information was provided prior to exit.	F 814	The surveyor did not find the other dumpsters on campus with the deficient practice. III System changes Facility will provide education to the maintenance and housekeeping staff on keeping the dumpster surroundings free of trash or refuse at all times. IV Monitoring In order to ensure ongoing compliance, the Maintenance Director or designee will conduct random audits of all dumpsters on campus weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. V Date of compliance 4/20/2020	
F 842 SS=D	Resident Records - Identifiable Information	F 842		4/20/20

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 _____	03/12/2020

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
F 842	Continued From page 38 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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 _____	03/12/2020

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
F 842	Continued From page 39 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 27 residents in the survey sample, Resident #25. Resident #25's physician orders documented an order for the use of side rails. Resident #25's bed was observed without side rails in place and the resident stated she did not want or use side rails.	F 842	F 842 It is the practice of this facility to maintain a complete and accurate clinical record of its residents. 1. Correction Resident #25 continued to decline the use	

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 _____	03/12/2020

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
F 842	Continued From page 40 The findings include: Resident #25 was admitted to the facility 10/10/19 with diagnoses that included but were not limited to: high blood pressure, scoliosis (abnormal lateral or sideward curve to the spine) (1), anxiety disorder, and low back pain. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/7/2020, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of two staff members, in bed mobility. Observation was made on 3/11/2020, at 9:43 a.m., of Resident #25 in bed with no side rails on her bed. When interviewed regarding side rails, Resident #25 stated she didn't want them. Review of the clinical record documented revealed a physician's order dated 2/6/2020, "May use 2 upper 1/4 side rails while in bed to assist resident with bed mobility & transfers while maintaining or obtaining their highest practicable level of physical care and to ensure resident's safety." An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 3/11/2020 at 5:40 p.m. When asked if a resident without side rails, on their bed should have a physician order for the use of side rails, ASM #2 stated, "No, not if they are not utilizing them."	F 842	of side rails while in bed. The side rail order for resident #25 has been discontinued due to resident□s verbalization of not wanting them on her bed. II Identification All residents have the potential to be affected by this deficient practice. All the residents in the facility currently using side rails have had their medical records audited for the presence of orders. III System changes The DON or designee will provide education to nursing staff on side rail orders and implantation. The clinical nursing staff will be educated on physician notification in the case of resident refusing an order for side rails for discontinuation of such an order. IV Monitoring In order to ensure ongoing compliance, the facility will conduct random audits of four residents on side rails weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality	

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 _____	03/12/2020

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
F 842	Continued From page 41 The facility policy, "Medical Records" documented in part, "Policy: (Name of facility) will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized." ASM #1, the administrator, and ASM #2 were made aware of the above concern on 3/11/2020 at 5:50 p.m. No further information was obtained prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 523.	F 842	Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. V Date of compliance 4/20/2020	