	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		
			B. WING		C 06/29/2023	
		VA0052				
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, ST RKE LAKE ROA			
URKE HE	EALTH & REHABILITAT		VA 22015			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 000	Initial Comments		F 000			
	Inspection was cond 6/29/23. The facility the Virginia Rules an Licensure of Nursing The census in this 12	20 licensed bed facility was survey. The survey sample				
F 001			F 001		8/1/23	
	The facility was out of following state licens	of compliance with the sure requirements:				
	This RULE: is not m 12VAC5-371-220 (C)	et as evidenced by:)(5) cross reference to F577		State Tags		
	12VAC5-371-370 (A)) cross reference to F584		12VAC5-371-220 (C)(5) cross reference F577	to	
	12VAC5-371-200 (B) F658)(1)(ii) cross reference to		12VAC5-371-370 (A) cross reference to F584		
	12VAC5-371-220 (D)) cross reference to F695		12VAC5-371-200 (B)(1)(ii) cross referen	CA	
	12VAC5-371-300 (A) F755) & (B) cross reference to		to F658		
	12VAC5-371-300 (B)) cross reference to F759		12VAC5-371-220 (D) cross reference to F695		
	12VAC5-371-300 (B)) cross reference to F761		12VAC5-371-300 (A) & (B) cross reference to F755		
	12VAC5-371-370 (A)) cross reference to F921		12VAC5-371-300 (B) cross reference to F759		
	12VAC5-371-75 (B)(12VAC5-371-300 (B) cross reference to		
	Based on staff interv	iew and facility		F761		
	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE 07/17/23	

STATE FORM

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If continuation sheet 1 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		VA0052	B. WING			C 29/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
BURKE H	EALTH & REHABILITATI	ON CENTER	RKE LAKE ROA VA 22015	٨D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLET DATE
F 001	Continued From page	e 1	F 001			
	have evidence of a si	w, the facility staff failed to igned sworn statement, on or ployees, Staff #5, #15, and 5 employee records		12VAC5-371-370 (A) cross referer F921	ice to	
	reviewed. The findings included: On 6/28/23, a review of 25 employee files was conducted and revealed the following:			12VAC5-371-75 (B)(1) Sworn State	ement	
				 Employee # 5 is no longer emp Staff Member # 15 and # 25 has a statement present in the HR file. Newly Hired employees are at ri 	sworn	
		l on 7/22/21. The facility rovide evidence that a sworn ned from Staff #5.		 audit of all current employees are at final audit of all current employees to entite that a sworn statement is present final employee. The Administrator or designee with the statement of the s	nsure [:] or each	
	2. Staff #15 was hired statement was obtain 11/29/21.	d on 1/29/21. A sworn ned from Staff #15 on		educate the Director of Human Re on hiring practices and requirement newly hired employees. 3. The administrator of designee w	sources its for	
	3. Staff #25 was hired statement was obtain 12/10/22.	d on 5/27/21. A sworn ned from Staff #25 on		all newly hire employee files week ensure sworn statement obtain per 5.Results of the monitoring will be	y to r policy.	
	Director of Clinical Se "The purpose of obta before hiring a potent them attest that they	timately 4:00 PM, an oted with the Regional ervices (RDCS) who stated, ining a sworn statement tial staff member is to have do not have any outstanding ore starting their employment		presented to the QAPI committee to review and recommendations. O QAPI determines the problem no le exists, the monitoring will be condu- a random basis. 6. Date of Compliance August 1, 2	nce the onger ucted on	
	On 6/28/23 at approx Administrator and Dir	timately 5:30, the Facility rector of Nursing were gs. No further information		 12VAC5-371-75 (B)(3) Criminal Background 1. Employee #5 is no longer an er of the facility. Employee #15 and # have a criminal background check was obtained after their hire date in 	#20 that n their	
	12VAC5-371-75 (B)(3	3)		file. Employee # 25 a criminal bac check was obtained on 6/28/23.	kground	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	(X3) DATE SURVEY COMPLETED			
			A. BUILDING:			
		VA0052	B. WING		C 06/29/2023	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
URKE H	EALTH & REHABILITATI	ON CENTER	RKE LAKE ROA VA 22015	ND		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
F 001	Continued From pag	e 2	F 001			
	Based on staff interview and facility			2. Newly hired employees are at risk.	An	
				audit of current employees to ensure		
		w, the facility staff failed to		a criminal background check is prese	nt in	
		ord report from the Virginia		the employee file.		
	-	Police within 30 days of hire		3. The Administrator or designee will		
		ff #5, #15, #20, and #25, in a		educate the Director of Human Resou		
	sample of 25 employ	ee records reviewed.		on hiring practices and requirements	lor	
	The facility staff faile	d to obtain a ariminal		newly hired employees.	audit	
	,	ithin 30 days of hire for Staff		4. The administrator of designee will a all newly hire employee files weekly to		
	#5, #15, #20, and #2	-		ensure criminal background is presen		
	$\pi 0, \pi 10, \pi 20, and \pi 2$	5.		prior to the start per policy.		
	The findings included	4.		5.Results of the monitoring will be		
	····e·····ge····e·uee			presented to the QAPI committee for		
	1. Staff #5 was hired	7/22/21 and terminated		review and recommendations. Once	e the	
	employment on 4/24/22. The facility was unable			QAPI determines the problem no long	jer	
		hat Staff #5 had a criminal		exists, the monitoring will be conducted		
	background check pe	erformed. Therefore, from		a random basis.		
	7/22/21-4/24/22, facility staff were unaware of Staff #5's criminal background status and was			6. Date of Compliance August 1, 2023	3	
	permitted to provide	direct care to Residents.				
	2. Staff #15 was hire	d 1/29/21. Staff #15's				
	criminal background	check was dated 11/18/21.				
	Therefore, from 1/29	/21-11/18/21, facility staff				
		ff #15's criminal background		12VAC5-371-210 (E) Verify Professio	nal	
	status and was perm Residents.	itted to provide direct care to		Nursing Lic		
				1.Employee #5 no longer works at the)	
		d 8/6/21. Staff #20's criminal		facility.		
	background check w			2. Current residents are at risk.		
		21-11/21/22, facility staff were		An audit of current licensed staff will l		
		's criminal background		conducted to ensure that current licen		
	Residents.	itted to provide direct care to		verification in present in the employee file. 3. The Administrator or designee		
	NGSIGENIS.			educate the Director of Human Resou		
	4 Staff #25 was hire	d 5/27/21. Staff #25's		on hiring practices and requirements		
		check was dated 6/28/23.		newly hired employees.		
		/21-6/28/23, facility staff		4. The administrator of designee will a	audit	
		ff #25's criminal background		all newly hire employee files weekly to		

STATE FORM

STATEMENT	/irginia OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING.		с
		VA0052	B. WING		06/29/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
BURKE HI	EALTH & REHABILITATI	ON CENTER		ND	
		•	VA 22015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLE
F 001	Continued From pag	e 3	F 001		
	status. On 6/28/23 at approximately 4:00 PM, an interview was conducted with the Regional Director of Clinical Services (RDCS) who stated, "We get criminal background checks on everyone before they are hired to be sure there is no criminal history, no history of abuse or barrier crimes, we want to make sure that they can be trusted and to ensure the safety of our residents". The RDCS verified that Staff #5, #15, #20, and #25 did not have a criminal background report within 30 days of their respective hire dates.			 ensure licensure verification was performed prior to the start date employee per policy. 5.Results of the monitoring will be presented to the QAPI committee review and recommendations. QAPI determines the problem no exists, the monitoring will be condared a random basis. 6. Date of Compliance August 1, 	for the e e for Once the longer ducted on
	subtitle, "Procedure", background and refe on all employees". On 6/28/23 at approx Administrator and Dir updated on the findin was provided. 12VAC5-371-210 (E) Based on staff intervi documentation review verify the professiona Staff #5, in a sample nurse employee reco	ppropriation/Crime g/Training", dated 1/23/20, , item 1 read, "Criminal rence checks are performed kimately 5:30, the Facility rector of Nursing were ags. No further information be wand facility w, the facility staff failed to al nursing license for 1 nurse, of 10 licensed professional brds reviewed. The facility he nursing license was active		 12VAC5-371-210 (F)(1) Verify CN Certification 1.Employee #15 has a current certification 1.Employee #15 has a current certification in his employment file. 2. Current residents are at risk. An audit of current certified staff conducted to ensure that current verification in present in the emplofile. 3. The Administrator or designee educate the Director of Human R on hiring practices and requirement newly hired employees. 4. The administrator of designee all newly hire employee files wee ensure certification verification was performed prior to the start date for employee per policy. 5.Results of the monitoring will be presented to the QAPI committee review and recommendations. 	ertification will be licensure loyee⊡s will resources ents for will audit kly to as for the e e for Once the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		VA0052	B. WING		C 06/29/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
BURKE H	EALTH & REHABILITATI	ON CENTER	RKE LAKE ROA VA 22015	ND	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLE
F 001	Continued From page	e 4	F 001		
	record was conducted 7/22/21. Staff #5's nu dated 4/5/22. Therefo	of Staff #5's employee d. Staff #5 was hired on Irsing license verification was ore, from 7/22/21-4/5/22, vare if Staff #5's license was		a random basis. 6. Date of Compliance August 1, 2	023
	active and in good standing.			12VAC5-371-260 (B)(11) Annual T PU for Nurse	raining
	Director of Clinical Se "The purpose of obta to make sure that we to take care of our re- is no disciplinary action On 6/28/23 at approx Administrator and Dir	eted with the Regional ervices (RDCS) who stated, ining a license verification is are hiring qualified people sidents and to ensure there		 Registered Nurse s E Annual Prevention/Treatment of Pressure was completed on 7/13/23. Current residents are at risk. An all resident care staff will be complidentify employees that have not completed the annual Prevention/Treatment of Pressure The Director of nursing or design educate all resident care staff on the staff on the staff on the staff. 	Audit of eted to Sores. nee will
	was provided. 12VAC5-371-210 (F) Based on staff intervi documentation review verify the certification	(1)		Prevention/Treatment of Pressure ensure annual education is comple 4. The SDC or designee will audit employee education files on their a hire date to ensure all mandatory education was completed. 5.Results of the monitoring will be presented to the QAPI committee f review and recommendations. O QAPI determines the problem no lo exists, the monitoring will be condu- a random basis.	sores to eted. Innual for nce the onger
	certification was activ	cility staff failed to verify that the ation was active and in good standing for 15 prior to allowing Staff #15 to provide resident care.		6. Date of Compliance August 1, 2	
	The findings included	l:		12VAC5-371-290 (B) Verify Therap	DY LIC
	record was conducted	of Staff #15's employee d. Staff #15 was hired on rertification verification was		 Employee # 20 has a current certification in his employment file. Current Residents are at risk. An audit of current licensed therap 	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
			A. BUILDING:			
		VA0052	B. WING		06/29/2023	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, ST			
BURKE HI	EALTH & REHABILITATI	ON CENTER	RKE LAKE ROA VA 22015			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
F 001	Continued From page	e 5	F 001			
F 001	Continued From page 5 dated 11/18/21. Therefore, from 1/29/21-11/18/21, facility staff was unaware if Staff #15's certification was active and in good standing. Staff #15 was permitted to provide direct care to Residents. On 6/28/23 at approximately 4:00 PM, an interview was conducted with the Regional Director of Clinical Services (RDCS) who stated, "The purpose of obtaining a license verification is to make sure that we are hiring qualified people to take care of our residents and to ensure there is no disciplinary action on their license". On 6/28/23 at approximately 5:30, the Facility Administrator and Director of Nursing were updated on the findings. No further information was provided. 12VAC5-371-260 (B)(11) Based on staff interview and facility documentation review, the facility staff failed to ensure resident care staff received annual in-service training for 1 employee, RN E, in a sample of 5 employee training records reviewed. The findings included:			 will be conducted to ensure that current licensure verification in present in the employee s file. 3. The Administrator or designee will educate the Director of Human Resourt on hiring practices and requirements in newly hired employees. 4. The administrator of designee will a all newly hire employee files weekly to ensure license verification was perform prior to the start date for the employee policy. 5.Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once QAPI determines the problem no long exists, the monitoring will be conducted a random basis. 6. Date of Compliance August 1, 2023 	audit o med e per e the ler ed on	
	1/1/22 through 6/28/2	the area of				
		imately 5:30 PM, the Facility ector of Nursing (DON)				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE S COMPL		
			A. BUILDING:			С	
		VA0052	B. WING		06/2	29/2023	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
BURKE H	EALTH & REHABILITATI	ON CENTER	VA 22015				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE	
F 001	Continued From page	e 6	F 001				
	were updated on the information was prov	findings. No additional ided.					
	12VAC5-371-290 (B)						
	verify the professional licensed staff member	iew and facility w, the facility staff failed to al therapy license for 1 er, Staff #20, in a sample of 1 f employee record reviewed.					
	The findings included:						
	record was conducte 8/6/21. Staff #20's proverification was dated 8/6/21-4/4/22, facility #20's professional the	of Staff #20's employee d. Staff #20 was hired on ofessional therapy license d 4/4/22. Therefore, from staff were unaware if Staff erapy license was active and aff #20 was permitted to b Residents.					
	Director of Clinical Se "The purpose of obta to make sure that we	cted with the Regional ervices (RDCS) who stated, ining a license verification is are hiring qualified people sidents and to ensure there					
	Administrator and Dir	timately 5:30, the Facility rector of Nursing were gs. No further information					