**FOIA Data Base** - The Law Office of Jeffrey Downey Serving clients in Washington D.C., Virginia and Maryland

If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation.

Phone: 703-564-7318;

email: [jdowney@jeffdowney.com](mailto:jdowney@jeffdowney.com)

Arleigh Burke Pavilion 1739 Kirby Road

McLean, Virginia 22101

Facility Characteristics:

* Skills Nursing Facility with 49 beds
* Non Profit – Corporation
* Legal Business Name – Vinson Hall LLC
* Ownership: New Marine Coast Guard Resident Foundation since 6/17/2011
* Managing Employee: Kathryn Branch since 8/8/2011

As of 2018 Arleigh Burke Pavilion was evaluated as a four-star facility on Medicare.gov

**Researching Nursing Homes**

A note by attorney Jeffrey J. Downey:

Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The Virginia Department of Health inspects nursing homes including Evergreen Health and Rehabilitation. Periodically they do inspections as complaint surveys

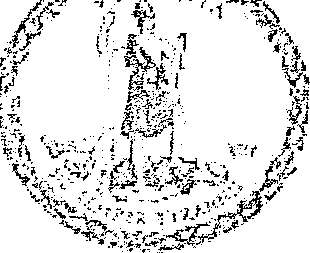
which should be public record. State law requires that all nursing facilities obtain a license to operate in Virginia. There are more than 279 nursing facilities containing 31,927 beds located throughout Virginia. All but fifteen nursing facilities are certified for federal reimbursement under Medicare and Medicaid. In Virginia, nursing facilities and inspected every two years under the state

licensure and on an average of 12 months under Medicare/Medicaid certification. When the Virginia Office of Licensure and Certification (OLC) conducts inspections and investigations in response to complaints received from the public, the identity of the complainant and the identity of any patient who is the subject of the complaint, or identified therein, shall be treated as confidential and shall not be open to inspection by members of the public. Nothing contained herein shall prevent the OLC or its employees from making reports under §63.2- 1603 et. seq. of the Code of Virginia. (Ref. §32.1- 127.1:03 of the Code of Virginia) You can register a complaint by mailing to Virginia Department of Health, Office of Licensure and Certification, Virginia Department of Health, 9960 Maryland Drive, Suite 401, Henrico, VA 23233-1463 or via email at [OLC-](mailto:OLC-Complaints@vdh.virginia.gov) [Complaints@vdh.virginia.gov](mailto:OLC-Complaints@vdh.virginia.gov).

Having already researched Envoy of Westover Hills and obtained FOIA responses, I am posting these statements of deficiencies here, in a searchable format. Keep in mind that these surveys have been altered during the conversion process and you should update your search results.

I am interested in any additional information you may have on this facility. Please call me with any question about this or any other facility you may be interested in searching or prosecuting civilly for patient neglect or abuse.

**Disclaimer:** Information is built using data sources published by Centers for Medicare & Medicaid Services (CMS) under Freedom of Information Act (FOIA). The information disclosed on the NPI Registry are FOIA-disclosable and are required to be disclosed under the FOIA and the FOIA amendments to the FOIA. There is no way to 'opt out' or 'suppress' the NPPES record data for health care providers with active NPls. Some documents may not be accurately copied or some results may have changed upon appeal, which may not be noted here.



M. Norman Oliver, MD, MA State Health Commissioner

*1COlVIM ON vVEALTl'I of VIRGINIA*

*Department of Health*

Office of Li censure and Certification TYY?-1-1 OR

1-800-828-1120

9960 Mayland Drive, Suite 401

Henrico, Virginia 23233-1485

Fax (804) 527-4502

February 20, 2019

Mr. Robert Demaria, Administrator Arleigh Burke Pavilion

1739 Kirby Road

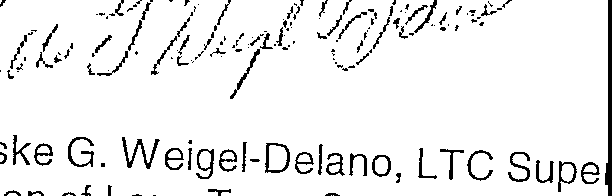
Mc Lean, VA 22101

RE: Arleigh Burke Pavilion Provider Number 495410

Dear Mr. Demaria:

Based on deficiencies cited during the survey ending January 31, 2019, your facility was found not to be in substantial compliance with the Federal participation requirements for the long term care Medicare/Medicaid program. The deficiencies cited during the most recent onsite survey did not result in a Scope and Severity grid placement of "G" through "L" *or* a finding of Substandard Quality of Care (grid placements of "F" and "H" through "L").

By copy of this letter, we are notifying the Centers for Medicare and Medicaid Services (CMS) and/or the state Medicaid agency (Virginia Department of Medical Assistance Services DMAS) that based on our acceptance of the previously received Plan of Correction (PoC), your Allegation of Compliance (AoC) of February 15, 2019, we will presume substantial compliance with CFR Part 483, Subpart B, at this time. **Please be *advised* that compliance with the *above* listed Health requirements does not necessarily end the Federal enforcement track You must also achieve compliance with the Life Safety Code in order to end any enforcement action that may be in effect.** Failure to maintain substantial compliance may result in denial of Medicare and/or Medicaid payments for new admissions, the imposition of other Federal *or* State remedies, *or* termination of the provider agreement.

If you have any questions concerning the content of this letter, please contact me at (804) 367-2100. Sincerely,

Wietske G. Weigel-Delano, LTC Supervisor Division of Long Term Care Services

cc: Bertha Ventura, DMAS ( Sent Electronically)

Joani Latimer, State Ombudsman (Sent Electronically)

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M. Norman Oliver, MD, MA State Health Commiss·1oner

##### *COMMONWEALTH of VIRGINIA*

*Department of Health*

Office of Liccnsure and Certification TYY7-1-1 OR

**1·800-828-1120**

9960 Mayland Drive, Suite 401

Henrico, Virginia 23233-1485

Fax (804) 527-4502

February 5, 2019

Mr. Robert Demaria, Administrator Arleigh Burke Pavilion

1739 Kirby Road

Mc Lean, VA 22101

RE: Arleigh Burke Pavilion Provider Number 49541o

Dear Mr. Demaria:

An unannounced standard survey, ending January 31, 2019, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. No complaints were investigated during the survey.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483 1O(g), the current survey report must be. made available for examination in a place readily accessible to residents and is discl6sable to all interested parties.

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Mr. Robert Demaria, Administrator February 5, 2019

Page2

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (SIS of E), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC}

A PoC is not required tor de1iciencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (1O) calendar days of receipt of these survey findings to Wietske G. Weigel-Delano, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all c.orrec.tions must be made is the 45th calendar day after the survey ended.)

**The PoC will serve as the facility's allegation of compliance.** If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

**Following the receipt and review of your survey report,** please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at http://www.1/dh.virginia.gov/licensure-and-certification/the-division-of-long-term-care/.

Mr. Robert Demaria, Administrator February 5, 2019

Page 3

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing ihose deficiencies, to: Director, Division of Long Term Care, Office of licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 1O calendar days of your receipt of the enclosed survey findings.

**An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.**

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

* + Pursuant to §488.408(c)
    - Directed Plan of Correction (PoC) (§488.424).
    - State monitoring (§488.422).
    - Directed In-Service Training (§488.425).
  + Pursuant to §488.408(d)
    - Denial of payment for new admissions - (§488.417).
    - Denial of payment for all individuals - (§488.418).
    - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,
  + Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

**Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare** & **Medicaid Services or the Virginia Departr:nent of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey** identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

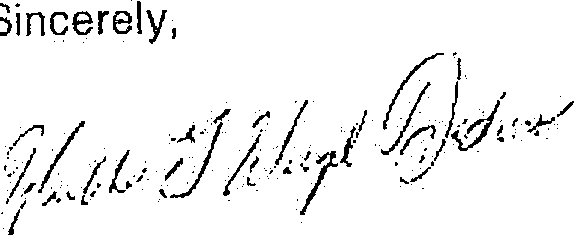
Mr. Robert Demaria, Administrator February 5, 2019

Page 4

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: ["http://www.vdh.virginia.gov/OLC/Downloadables/documents/201l/pdf/LTC%20facility%20survey%20respon](http://www.vdh.virginia.gov/OLC/Downloadables/documents/201l/pdf/LTC%20facility%20survey%20respon) se%20form.pdf". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.



Wietske G. Weigel-Delano, LTC Supervisor Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman

Bertha Ventura, Dmas ( Sent Electronically )

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

PRINTED; 02/05/2019 FORM APPROVED OMBNO. 0938·0391

STATEMf:.NTOF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

ARLEIOH BURKE PAVILION

(X1) PAOVIOEJVSUPPLIEFVCLIA IDENTIFICATION NUMBER:

495410

(X2) MULTIPLE CONSTRUCTION

1. BUILDING \_
2. WING

STREET AODRl:SS, CITY, STATE, ZIP CODE

**1739 KIRBY ROAO**

**MC LEAN, VA 2210.1**

{X3) DATE SURVEY COMPLETED

01/31/2019

(X4)10 PHEFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH O1:FICfENCY MUST BE PRECEDED. BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ElE

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DEFICIENCY)

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E ooo Initial Comments

An unannounced Emergency Preparedness

. survey was conducted 1/29/19 through 1/31/19.

I The facility was In substantial compliance with 42 CFA Part 483.73, Requirement for Long-Term Care Facilities.

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 1/29/19 through 1/31/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey.

The census in this 49 certified bed facility was 47 at the time of the survey. The survey sample consisted of 22 resident reviews,

F 622 Transfer and Discharge Requirements

SS=D **CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(ili)**

§483.15(0) Transfer and discharge­

§483.15(0)(1) Facility requirements•

* 1. The facility must permit each resident to remain In the facility, and not transfer or discharge the resident from the facility unless­

{A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met In the facility;

1. The transfer or discharge is appropriate because the resident's health has Improved sufficiently so the resident no longer needs the

· services provided by the facility;

1. The safety of Individuals In the *taclllty* Is endangered due to the clinical or behavioral status of the resident;

D) The health of individuals in the facility would

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F 622

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POCABP 2019

The statements made in this plan of Correction are Not an admission to and do not constitute an Agreement with the alleged deficiencies. To remain in compliance with all Federal and State regulations, the center has taken or will take the Actions set forth in this

plan of correction. The plan of Correction constitutes the centers allegation of Compliance such that all alleged Deficiencies cited have been or will

be corrected by the date or dates indicated.

F 622 Transfer and Discharge Requirements

l.Resldent 1143 had no adverse effects. 2.AII residents receiving care have the potential to be affected,

1. The facility will conduct an audit of all residents to assure they have comprehensive care plan goals.

4, The facility has Instituted a new form and a new process to assure that all residents transferred will have a set of comprehensive care plans provided for a hospital transfer.

* 1. All hospital transfers will be reviewed dally In Hawk Room to assure **a** copy of the comprehensive care plans were provided to the hospltal,

If not they will be faxed that day.

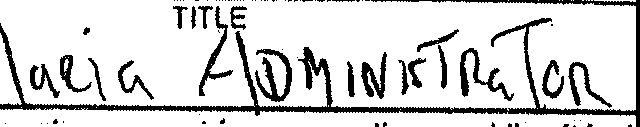
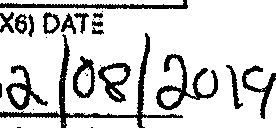
0. Education will be provided to all Nursing staff on the new process.

S. In order to assure on going compliance the facility will conduct a random audit of 4 transfer records, this

audit will be conducted weekly X weeks and monthly X *4* months.

1. All findings will be submitted to QA for review and recommendations.
2. The corrective action will be completed by February 15, 2019.

E'S SIGNATURE \_



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ng witti..a,rtl"sterisk ('l denotes a deficiency which lhe Institution *may* be excused from correcting providing it Is determine that other safeguards provides clent protection to the patients. (See Instructions.) Except for nursing homes, th8 lindlngs stated above are disclosable 90 days following th8 date of su1Vey whether or not a plan of correction lo provided. For nursing homes, the above findings and plans or correction are dlsclosable 14 days follov.1ng the date lhese documents are made available to the facility. If deficiencies are cited, an approved plan ol correction Is requisite to continued program participation.

FORM CMS<t5ff/(02•U'J) Previous Versions Otlsolo1e Evenl ID:190811 Facility ID: VA0407 If continuation sheet Page 1 of 10

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

PRINTED: 02/05/2019 FOAM APPROVED 0MB NO 0938·0391

FORM CMS·2567(02,99) P1evious Versions Obsole!e Eve111 10: 100811 Facility 10: VA0407 If continuation sheet Page 2 of 10

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| STATEMENI OF DEFICICiNGIES  AND PLAN OF CORRECTION | | (XI) PHOVIOEA/SIJPPLIER/CLIA  IDENTIFICATION NUMBER:  495410 | | (X2) MUL1'1PLE CONSTRUCTION  A. BUILDING \_   1. WING | | | | | | (X3) DATE SURVEY  COMPLETED  01/31/2019 | | | |
| NAME OF PROVIDER OR SUPPLIER  ARLEIGH BURKE PAVILION | | | | | STREET ADDRES  1739 KIRBY RO  **MC LEAN, VA** | | S, CITY, STATE,  AD  **22101** | ZIP | CODE | | | | |
| (X4) ID PREFIX TAG | SUMMAfW STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION) | | I ,o  ! PREFIX  TAG | | | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | | , | J  I | (X51 COMPLEflO>i DATE |
| F 622 , Continued From page 1  j otherwise be endangered;  (E) The resident has falied, alter reasonable and  1 appropriate notice, to pay for (or to have paid  under Medicare or Medicaid) a stay at the facility. | | | | F622 | |  | | | | | | | |
| Nonpayment applies if the resident does not submit the necessary papetwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a  ; resident only allowable charges under Medicaid;  or  (F) The facility ceases to operate.  (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to  § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.  §483.15(c)(2) Documentation.  ' When the facility transfers or discharges a resident under any of the circumstances specified In paragraphs (c)(i)(l)(A) through (F) of this section, the facility must ensure that the transfer  : or discharge is documented in the resident's medical record and appropriate information ls communicated to the receiving health care | | | | | | | | | | | | | |
| Institution or provider.  (I) Documentation in the resident's medical record must include:  (A) The basis for the transfer per paragraph (c)(1)  (i) of this section. | | | | | | | | | | | | |  |

DEPAfffMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICAnE & MEDICAID SERVICES

PRINTED: 02/05/2019 FORM APPROVED 0MB NO 0938·0391

STATEMENT OF OEFICIENCIES

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NAME OF PROVIDER OR SUPPLIER

ARLEIGH **BURK!: PAVILION**

(X1) PROVIDER/SUPPLIER/CUA JOENIIFICATlON NUMBER;

**495410**

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**1739 KIRBY ROAD**

**MC LEAN, VA 22101**

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**01/31/2019**

(X4) 10 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION

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F 622I Continued From page 2

(B) In the case of paragraph (c){i){l)(A) of this section, the specific resident need(s) tha1 cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facillly to meet the need(s).

1. The documentation required by paragraph (c) (2)(i) of this section must be made by·
   1. The resident's physician when transfer or discharge is necessary under paragraph (c) (1)
2. or (B) of this section; and
3. A physician when transfer or discharge is necessary undel' paragraph (c)(1)(i)(C) or (D) of this section.
4. Information provided to the receiving provider

. must include a minimum of the following:

{A) Contact information of the practitioner responsible for the care of the resident.

(8) Resident representative information Including contact Information

1. Advance Directive information
2. All special instructions or precautions for ongoing care, as appropriate.
3. Comprehensive care plan goals;
4. All other necessary information, Including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

This REQUIREMENT is not met as evidenced

i by:

! Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to evidence all required

documents were provided to the receiving hospital for a facility initiated transfer for one of 22 residents in the survey sample, Resident #43.

f 622

The facility staff failed to evidence that Resident #431s comprehensive care plan goals were

FORM CMS-2567(02-99) Prevl011s Ve,sions Obsolete Event ID; 19D811 Facility ID; V/10407 If continua!lon sheet Page 3 of 1O

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

PRINTED: 02/05/2019 FORM APPROVED 0MB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN *OF* CORRECTION

NAME OF PROVIDER OR. SUPPLIER

ARLEIGH BURKE **PAVILION**

(X1) PROVIDEA/SUPPLIEA/Cl.lA

IOENTIFIOATION NUMBER:

495410

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

1. WING ,

STREET ADDRESS, CITY, STATE, ZIP CODE

**1739 KIRBY ROAD**

**MC LEAN, VA 22101**

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(X3) DATE SURVEY COMPLETED

01/31/2019

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SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICl!:NCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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F 622] Continued From page 3

provided to the receiving provider for a facility initiated hospital transfer dated 12/1/18.

F622

The findings include:

Resident #43 was admitted to the facility on 1/6/2014 with a most recent readmission date of 12/6/2018. Diagnoses included but were not limited to: dementia with Lewy bodies (1), atrial fibrillation (2), pneumonitis (3), and Parkinson's

disease (4).

r

, The most recent MDS (minimum data set), a

I Medicare five day assessment, with an ARD (assessment reference date) of 121'15/18 coded

I

i the resident as having a score of three on the BIMS (brief interview for mental status) score, indicating the resident had severe cognitive impairment.

Review of Resident #43's clinical record revealed

, that she was sent to the hospital on 12/1/18. A nursing note dated 12/1/1 B at 4:27 p.m., documented "Assessment done, daughter at bedside nurse observed pt (patient) congested, vital signs 130/70, 84, 99.3, 02 sat 92% room air (Sic). Supervisor made aware of patient recent

vitals and patient congestion. Supervisor left a message for MD (medical doctor) about 11:30

a.m. at about 11:45 a.m. called placed to MD, MD updated of patient above condition, new order given to transfer patient to (name of Hospital) for further eval. (evaluation). Daughter at bedside made aware of MD orders. Daughter stated

'Thanks for everything' at about 12:15 p.m. Patient left facility awake and responsive via stretcher accompariied by 911 (emergency medical services) squad. Report given to (name of receiving provider) at (name of hospital) about

FOf"lM CMS•:?507(02·99) P,evious Versions Obsolete Event ID; 190811 Facility 10: VA0407 ti continuation sheet Page 4 or 10

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

PRINTED; 02/05/2019 FORM APPROVED 0MB NO 0938-0391

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ARLEIGH BURKE PAVILION

(Xi) PROVIOER/SUPPLIEfl/CLIA IDENTIFICArlONNUMBER:

495410

(X2) MULTIPLE CONSTRUCTION

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STREET ADOFIESS, CITY, STATE, ZIP CODE

1739 KIRBY ROAD

**MC LEAN, VA** 22101

(X3) DATE SURVEY COMPLETED

01/31/2019

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SUMMARY STATEMENT OF 01:F'IC!ENCIES (EACH OEFIC!ENCY MUST 13E PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIONJ

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

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F 622 1 Continued From page 4

. 12:28 p.m."

There was no evidence in the clinical record that Resident #43's comprehensive care plan goals were sent to the receiving provider for Resident #43's facility- Initiated transfer to the hospital

dated 121111 a.

On 1/30/19 at 1:16 p.m., an interview was conducted with LPN (licensed practical nurse) 113, unit manager. LPN #3 was asked what information is provided to hospital staff when a resident is transferred to the hospital. LPN #3 replied, "We send the face sheet, doctor's order, a physician order sheet, code status, a doctor's progress note, and a transfer form which summarizes the residents AOL's (activities of dally living). When asked if the facility provides the residents' the comprehensive care plan goals to the receiving provider, LPN #3 replied "No."

On 1/31/19 at approximately 8:24 a.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Nursing. ASM 1#2 was asked If the facility could evidence

, comprehensive care plan goars were sent to the

receiving provider for Resident #43's facility initiated hospital transfer dated, 12/1/18. ASM #2, replied "No, because the nurses have not sent the care plans consistently."

On 1/17/18 at approximately 10:51 a.m., ASM #1, the Administrator, ASM #2, the Director of Nursing and ASM #3, the nurse consultant were made aware of the findings.

No further information was provided prior to exit.

F 622

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FORM CMS-2567(02·99) Ptovious Verslof\S Obsolete EventlO:1908f I Facmiy ID: VA0407 If continuation shoet Page 5 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEF-lS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/05/2019 FORM APPROVED 0MB NO' 0938-0391

FORM CMS-2567(02·99) Previouc Vornlons Obsolete Event ID:19D811 Facility ID: VA0407 If continuation sheet Pago 6 ol 1O

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| STATEMENT OF DEFICIENCIES  ANO PLAN OF GORRE:CTION | (Xl) PROVIDl:RJSUPPLIERICLIA IDENTIFICATION NUMBER  4954·10 | (X2) MULTIPLE CONSTRUCTION A.BUILDING \_  B.WING | | | | | | | (X3) DATE SURVEY COMPLETED  01/31/2019 | | |
| NAME OF PROVIDER OR SUPPLIEHl  **ARLEIGH BURKE PAVILION** | | | | STREET ADDRES  **1739 KIRBY RO**  **MC LEAN, VA** | | S, CITY.  **AD**  **22101** | STATE. | 21? CODE | | | |
| **(X4)** ID SUMt,tARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEOl;D BY FULL  TAO REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID '  PREFIX 1•  TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CAOSS•REFERENCl:O TO THE APPROPRIATE DEFICIENCY) | | | | | i | tX5J COMPLETION OATE |
| F 622I Continued From page 5 [  ' 1. Dementia with Lewy bodies, sometimes called i Lewy body dementia, Is one of a group of brain disorders called "dementia." This group of brain disorders causes memory problems and makes it .  1 hard to think clearly. The cause of dementia with 1·  Lewy bodies (called "DLB" here) Is not known. It  1  gets its name from build-ups of protein in the  brain called "Lewy bodies" that can be found on an autopsy (an exam that is done after death). Lewy bodies are also seen-in the brains of people with Parkinson disease, which Is a brain disorder that affects movement. In people with DLB, the Lewy bodies are more widely spread throughout the brain than in people with Parkinson disease.  , This information was obtained from the website: .  ! [https:/Jwww.uptodate.com/contents/dementia-wit](http://www.uptodate.com/contents/dementia-withI)hI  ! -lewy•bodies-the-basics?search=lewy%20body<%  . 20dementia&topicRel=5087&source"'related\_link I  2. Atrial fibrillation is one of the most common  : types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes the heart to beat much faster than normal, and the upper and lower chambers of the heart do not work together. When this happens, the lower chambers do not fill completely or pump enough blood to the lungs and body. This can make you feel tired or dizzy, or you may notice heart  palpitations or chest pain, Blood also pools in the heart, which increases your risk or having a  - stroke or other complications. This information was obtained from the website: [https://www.nhlbi.nih.gov/health-topics/atrial•fibrill](http://www.nhlbi.nih.gov/health-topics/atrial) ation  3. Pneumonitis (noo•moe-NIE·tis) is a general term that refers to inflammation of lung tissue. 1  Technically, pneumonia Is a type of pneumonitis  because the infection causes Inflammation. | | | F6221  :  ' | | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PAINTED: 02/05/2019 FORM APPROVED 0MB **NO** 0938-0391

STATEMENT OF DEFICIENCIES

AND PLAN OF COA11ECTION

(X1) PFlOVI0EH/SUPPLIER/CLIA

IDENTIFICATION NUMBER;

(X2) MULTIPLE CONSTRUCTION

**A.** BUILDING. ··

(X3J DATE SURVEY COMPLETED

**495410**

fl.WING ,

**01/31/2019**

NAME OF PAOVIOE/1 OR SUPPLIE.R

**ARLEIGH BURKE PAVILION**

STREET ADDRESS. CITY, STATE, ZIP CODE

**1739 KIRBY ROAD**

**MC LEAN, VA 22101**

(X4) ID PHF.FIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PAECEDE0 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)

) **tX5)**

COMPLETION

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I DATE

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F 622 Continued From page 6

Pneumonitis, however, is usually used by doctors to ref er to noninfectious causes of lung inflammation. Common causes of pneumonitls Include airborne irritants at your job or from your

; hobbies. In addition, some types of cancer treatments and dozens of drugs can cause pneumonitis. Difficulty breathing - often accompanied by a dry (nonproductive) cough - is the most common symptom of pneumonitis.

Specialized tests are necessary to make a diagnosis. Treatment focuses on avoiding irritants and reducing inflammation. This information was obtained from the website:

* [https://www.mayoclinic.org/diseasesconditions/pn](http://www.mayoclinic.org/diseasesconditions/pn)

,1· eumonltls/symptoms-causes/syc-20352623?p:::i '

4. Parkinson1s Disease: A type of movement

: disorder. This information was obtained from the

- website:

I [https://www.nlm.nih.gov/rnedlineplus/parkinsonsdi](http://www.nlm.nih.gov/rnedlineplus/parkinsonsdi) sease.html.

F 880I Infection Prevention & Control

F622

i

F 8801

F 880 Infection: Preventiori and Control

SS=E: CFR(s): 483.80(a)(1)(2}(4)(e)(f}

§483.80 Infection Control

The facility must establish and maintain an infection prevention and control program

I

designed to provide a safe, sanitary and

! Cross Reference with 12VACS·371•340(A)

1. No residents had no adverse effects

'

1. AII residents receiving care have the potential to be affected. 3, The Ice machine air gap was corrected Immediately.

comfortable environment and to help prevent the I development and transmission of communicable diseases and infections.

§483.BO(a) Infection prevention and control

program.

The facility must establish an infaction prevention and control program (IPCP) that must include, at a minimum, the following elements:

i i

I 4. The facility will institute a new process to assure

I that the ice machine has an air gap.

1. tee machine gap will be checked on a monthly Basis and documented in a monthly log.

8. Education will be provided to all dietary staff on the new process.

1. In order to assure on going compliance the facility will

conduct a random audit of the air gap, this audit will be conducted weekly X weeks and monthly X 4 months. ,

1. All findings will be submitted to QA for review and recommendations.
2. The corrective action will be completed by February 15, 2019. I

FOAM CMS-2567(02·09) Previous Versions Obsolete Event ID: 190611 Facility ID: VA0407 If conllnualion sheet Page *7* of 10

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

PRINTED: 02/05/2019

. FORM APPROVED 0MB NO 0938-0391

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | (XI) PAOVIDEAiSUPPLIEHICUA IDENTIFICATION NUMBER  495410 | | (X2) MULTIPLE CONSTRUCTION   1. BUILDING ·-- 2. WING | | | | (X:l) DATE SURVEY COMPLETED  01/31/2019 | | | |
| NAME OF PROVIOER OR SUPPLIER  ARLEIGH BURKE PAVILION | | | | | SfREET ADDRESS, CITY, STATE. ZIP CODE  1739 KIRBY ROAD  **MC LEAN, VA** 22101 | | | | | |
| (X4) ID j **SIJMMARY** STATEMENT OF DEFICIENCIES PREFIX ', (EACH DEFICIENCY MUST BE PAEC(:(JEO BY FULL  TAG I REGULATORY OR LSO IDENTIFYING INFORMATION) I | | | | 10  PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS•REFERENCEO TO THE APPROPRIATE DEFICIENCY) | | I |  | (XS)  COMPLET!ON  OAfl: |
| \  F 880 Continued From page 7  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections  1  1 and communicable diseases for all residents,  staff, volunteers, visitors, and other individuals ' providing services under a contractual  i arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80{a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:  , (i) A system of surveillance designed to identify  . possible communicable diseases or  infections before they can spread to other  I persons in the facility; possible incidents   1. When and to whom of   communicable disease *or* infections should be reported;   1. Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how Isolation should be used for a resident; including but not limited to:    1. The type and duration of the isolation, depending upon the infectious agent or organism involved, and    2. A requlrement that.the isolation should be theI   I l ast restrictive possible for the resident under the circumstances.   1. The circumstances under which the facility   1 must prohibit employees with a communicable  disease or infected skin lesions from direct contact with residents *or* their food, if direct contact will transmit the disease; and   1. The hand hygiene procedures to be followed   *by* staff involved in direct resident contact.  §483.80(a)(4) A system for recording incidents  I | | .  i | | F 880  I | | I | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:180811 Fncllily ID: VA0407 If continuation sheet Paga 8 of 10

DEPARTMENT OF HEALTH AND HUMAN SEIWICES CENTERS FO MEDICARE & MEDICAID SERVICES

PFIINTED; 02/05/2019 FORM APPROVED 0MB NO 0936·0391

Sl'I\TEMENT OF DEFICIENCIES (X1) PAOVIDEA/SUPPLIER/CLIA (X2J MULTIPLE CONSTRUCTION (X3) DATE SURVEY

*AND* PLAN OF CORRECTION IDENTIFICATION NUMBER: A.BUILDING COMPLETED

495410 8.WING 01/31/2019

NAME OF PROVIDER OA SUPPLIER STREET ADDf1ESS, CITY, STATE. Zif' CODE

1739 KIRBY ROAD

ARLEIGH BURKE PAVILION

**MC LEAN, VA 22101**

TAG HEGULATORY OR LSC IDENTIFYING INFORMATION) TAO CHOSS-REFERENCED TO THE APPROPRIATE 0Af€

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| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | 10 | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE | COMPLl1TION |

. I !

DEFICIENCY)

F 880 Continued from page 6 F 880'

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' identified under the facility's IPCP and the '

, corrective actions taken by the facility.

§463.B0(e) Linens.

Personnel must handle, stol'e, process, and

transport linens so as to prevent the spread of !;

infection.

§483.80(/) Annual review.

The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, the facility staff failed to properly maintain an ice machine in a manner to prevent the spread of

disease for one of four facility ice machines. ;

'

The main kitchen ice machine did not have an air gap for the meltwater drain.

The findings included:

A tour of the facility kitchen was conducted on 01/29/19 at 11:45a.m. During the tour, it was noted that the main kitchen ice machine had a rneltwater drain protruding below the front of the machine, over a grate covered floor drain. Upon close inspection, the mouth of the pipe coming from- the ice machine was In direct contact with !

I

. the grate of the floor drain. I

On 01/30/19, the ASM (Administrative Staff Member) #1, the Facility Administrator, was made aware of the concerns regarding the ice machine.

ASM #'1 stated that the problem would be fixed ''

immediately.

: On the morning of 01/31/2019, at approximately !

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:190811 Facility ID: VA0<\07 If continuation sheet Page 9 of 10

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

PRINTED: 02/05/20 f 9 FORM APPROVED 0MB NO. 0938-0391



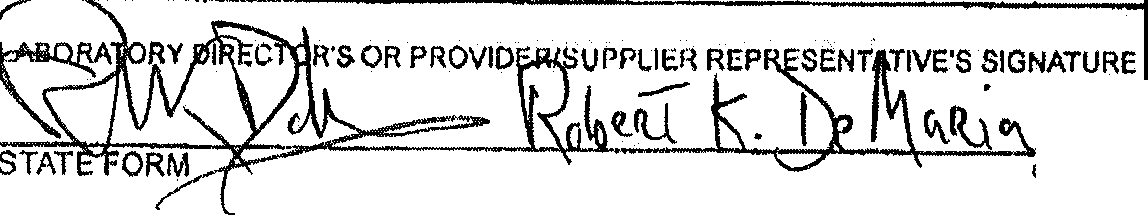
FORM CMS-2567(02-99) Previous Versions Obsofele Event 10: 190811 Facili(y 10: VA0407 tr conlinuallon sheet Pago 10 ol 10

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| STAl EMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (Xt) PROVIDEA/SUPPLIEAICLIA IOENTIFICATION NUMBER:  495410 | (X2) MULTIPLI: CONSTnUCTION  A BlJILOING  A.WING .. | | | | | | | | (X3) DATE SURVEY COMPLErEO  01/31/2019 | | | |
| NAME OF PROVIDER OR SUPPLIEf.l  AALEIGH BURKE PAVILION | | | | STREET ADD  1739 KIRBY  MC LEAN, | | RESS, CITY.  ROAD  VA 22101 | STATE, | ZIP | CODE | | | | |
| (X4) ID SUMMARY STATEMENT OF OEflCIENCIES I  PREFIX (EACH DEFICIENCY MUST Bf: PRl;CEDEO BY FULL 1  TAG REGULATORY on LSC IDENTIFYH-IG INFORMATION) | | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH COARECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIAlE | | | | | | ! | | IX !  CUM"!.ETION  OArl! |
| I | | | |  | DEFICIENCY) | | | | | | |  | |
| F 880 , Continued From page 9 | | | F 880 | | | | | | | | |  | |
| 19:00am, ASM #1 informed this surveyor that the I ice machine drain had been altered to have an air· gap. Inspection of the ice machine confirmed an  , air gap was now in place.  I The Administrator and Director of Nursing were informed of the findings1at the end of day meeting on 01/31/19. No further documentation was provided.  I  I  I  I | | | | | | | | | | | | | |

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | (X 1) PHOVIOER/SUPPLIERJCLIA IDENrlFICATION NUMUER:  **VA0407** | (X21MULl'IPLE CONSTRUCTION  A OlllLDING  6 WING | (X3) OATE SURVEY COMPLETED  01/31/2019 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  ARLEIGH BURKE PAVILION **1739 KIRBY ROAD MC LEAN, VA 22101** | | | |
| {X4)10 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S Pl.AN OF CORRECTION (XSJ PREFIX (EACH DEFICIENCY MUSi BE PRECEDED BY FULL PREFIX (EACH CORRECilVE **ACTION** SHOULD DE COMPLETE TAO REGULATORY OR LSC IDENTIFYING INFORMATION) TAO CROSS•REFERENCEO TO THE APPROPRIATE DATE  DEFICIENCY) | | | |
| F ooo Initial Comments FOOO  An unannounced biennial State Licensure Inspection was conducted 1/29/19 through 1/31/19. The facility was not in compliance with the Virginia Rules and Regulations for the Llcensure of Nursing Facilities. No complaints were investigated during the survey.   * The census in this 49 licensed bed facility was 47 at !he time of the survey. The survey sample consisted of 22 resident reviews.   F 001 Non Compliance F 001  The facility was out of compliance with the following state licensure requirements:  This RULE: is not met as evidenced by: 12 VAC 5-371-140 E3b -The Facility will obtain criminal  12 VAC 5 - 371 - 140 E 3b. Background checks within 30 clays of hire  Based on staff interview, facility document review, '. l.No residents were adversely affected.  and employee record **review,** it was determined • Z,AII residents receiving care have the potential to be affected.  the facility staff failed to obtain criminal 3. The facility will conduct an audit of all new hires since January 1, 2018  b k to assure they had a criminal background check completed  ac ground checks within 30 days of hire, for Within 30 days of hire, if not corrective measures will be taken.  three of 20 employee records reviewed, LPN 4. The facility will institute a new process to assure all new hires   * (licensed practical nurse) #1, **LPN #2** and have a criminal background check completed within 3o days of hire.   CNA(certified nursing assistant) #1. A. New Hire Check list has been revised.  B. A reminder will be set up to assure the criminal background   * 1. The facility staff failed to obtain the criminal check has been completed within 30 days of the hire/orientation date.   background check within 30 days of hire for LPN, C. The HR director will check and initial the date criminal  #1, background checks are received and reviewed,  D. Education will be provided to all HR staff on the new process.   * 1. The facility staff failed to obtain the criminal S. In order to assure on going compliance the facility will conduct an audit   for all new hires to assure background check was completed within 30 days  background check within 30 days of hire for LPN of hire this audit will be conducted monthly *X* 4 months.  #2. 6. All findings will be submitted to QA for review and recommendation.  7. The corrective action will be completed by February 15, 2019.   * 1. The facility staff failed to obtain the criminal background check within 30 days of hire for CNA #1. | | | |

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| STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION | (X1) PftOVIDERJSUPPLIER/CUA IDENTIFICATION NUM0ER  VA0407 | (X2) MULTIPLE CONSTRUCTION  A BUILDING: \_  6WING | {X3) DATE SURVEY COMPLETED  01/31/2019 |
| NAME OF PROVlDER OH SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE  ARLEIGH BURKE PAVILION **1739 KIRBY ROAO MC LEAN, VA 22101** | | | |
| (X4) 10 SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION : (,XS)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE ! COMPLETE  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS•REFERENCEO TO THE APPROPRIATE DATE  DEFICIENCY)  F 001 Continued From page 1 j F001  I  The findings include:  I  !   1. The facility staff failed to obtain the criminal   background check within 30 days of hire tor LPN  #1.  The employee record was reviewed for LPN #1. LPN #1's criminal background check was completed on 9/4/18. LPN #1 's hire date was 10/17118.  :  An interview was conducted with other staff  member (OSM) #1, the director of human resources, on 1/30/19 at 1:52 p.m. When asked , how soon within employment should the criminal background checks be completed, OSM #1  stated, "Within 30 days." When asked why LPN was #1's criminal background check was ; completed 73 days prior to hire, OSM #1 stated, "She was offered the job on 10/4/18, she ! accepted the position on 10J7/18 and started on 10/17/18.   1. The facility staff failed to obtain the criminal background check within 30 days of hire for LPN #2.   The employee record was reviewed for LPN #2. LPN #2's criminal background check was , completed on 6/10/18. An interview was , conducted with other staff member (OSM) #1, the ' director of human resources, on 1/30/19 at 1:62 ;  p.m. When asked why LPN #2's criminal background check completed, 40 days prior to hire, OSM #1 stated, "She was interviewed on  . 5/10/18. She was offered the Job on 5/30/18 and, worked another job so she had to give two-week l notice so she started on 6/20/18. | | | |

STATE FORM EUVC11 lf continuation sheet 2 of 3

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| STATEMENr OF DEFICIENCIES  AND PLAN OF CORRECrlON | (X l) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUM0ER  VA0407 | (X2) MULTIPLE CONSmUCTION  A BUILDING ···-·---  8. WING | | | | {X:l} DATE SURVEY COMPLETED  01/31/2019 | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE.  ARLEIGH **BURKE PAVILION 1739 KIRBY ROAD MC LEAN, VA 22101** | | | | | ZIP CODE | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PHEFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IOENrlFYING INFORMATION) | | | IU PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY) | | | : | **(XS)** COMPLETE DATE |
| F 001 Continued From page 2  3. The facility staff failed to obtain the criminal background check within 30 days of hire for CNA #1  The employee record was reviewed for CNA #1. CNA #1's criminal background check was completed on 8/31/18. An interview was conducted with other staff member (OSM) #1, the  director of human resources, on 1/30/19 at 1:52 , p.rn. When asked why CNA#1's criminal 1  background check was completed 33 days prior to hire, OSM #1 stated, "She was offered the job on 9/18/18 and accepted the position. She was scheduled for orientation on 9/26/18, She could not attend orientation on that day and then started on 10/3/18.  The facility policy, "Abuse" documented in part, "Prevention: c. Criminal records checks will be obtained in accordance with state law and/or facility policy,"  ASM (administrative staff member) #1, the administrator, was made aware of the above findings on 1/30/19 at 4:15 p.m.  No further information was obtained prior to exit.  12VAC5-371-340. Dietary and Food Service Program  12VAC5 371-340(A) cross reference to F880 | | | F 001 | | | | | |

STATE FORM EUVC11 If continuation sheet 3 of 3





#### Commonwealth of Virginia Virginia Department of Health

Nursing Home License Number: **NH2480**

*In accordance with the provisions of Title 32.1. Chapter 5, Article 1, of the Code of Virginia 1950 , as amended.*

**Vinson Hall, LLC**

(Operator)

**is Authorized to Operate,**

**Arleigh Burke Pavilion**

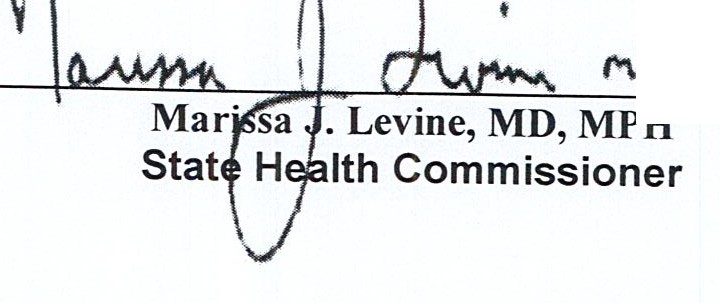
(Name of Organization)

**a Nursing Home, located at:**

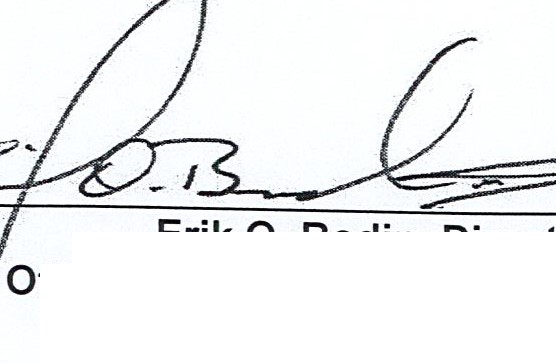
**1739 Kirby Road, McLean, Virginia 22101**

Approved Capacity **49** Beds Expiration 12/31/2016

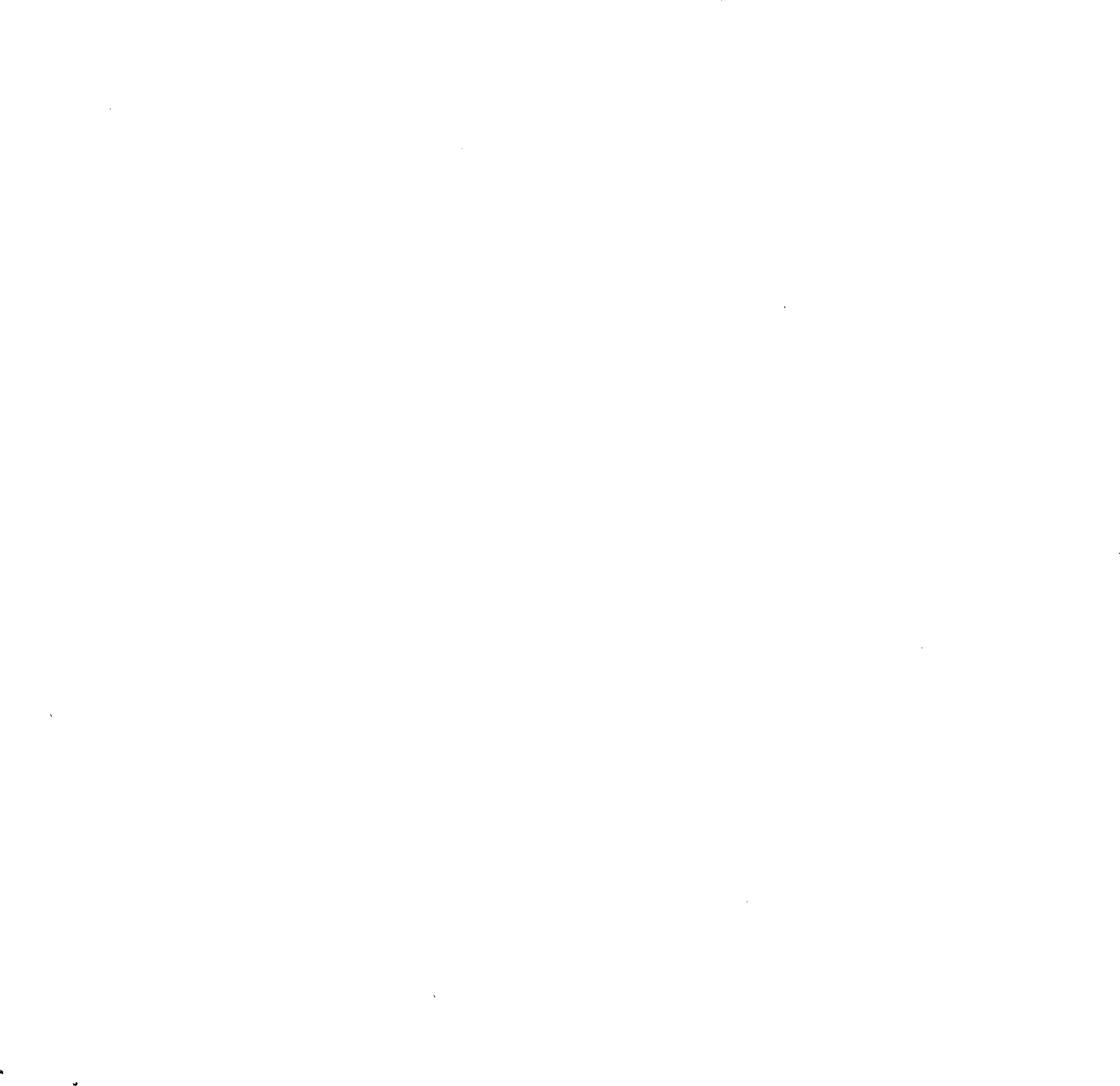
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Erik 0. Bodin, Director Office of Licensure and Certification



NURSING IIOME APPLICATION

**VIRGINIA STATE DEPARTMENT OF HEALTH APPLICATION FOR NURSING HOME LICENSE**

In accordance with the provisions of Chapter 5, Article I, Title 32.1, Code of Virginia of I 950, all non-federal medical and nursing facilities desiring license as a nursing home in Virginia must submit the following information to the Virginia Department of Health.

ANY CHANGES DURING THE YEAR WHICH WOULD AFFECT THE ACCURACY OF THE FOLLOWING INFORMATION MUST BE REPORTED PROMPTLY, IN WRITING, TO THE VIRIGNIA DEPARTMENT OF HEALTH.

 **REQUE.'i'l'li:D** IIFF'E(':TIVE **DA**ff: 01/01/2016

(month/day/year)

0 ANNUAL RENEWAL FOR CALENDER YEAR 2016

0 INITIAL LICENSE TO OPERATE A NURSING HOME

0 CHANGES IN LICENSED BED CAPACITY

0 CHANGES IN OWNERSHIP OR OPERATOR

NAME OF FACILrTY: Arleigh Burke Pavilion

**PHYSICAL ADDRESS:** 1739 Kirby Road

**(NUMBER** & **STREET)**

**CITY OR TOWN: McLean, VA 22101**

**CITY, STATE** & **ZIP CODE**

**COUNTY:** Fairfax

(703} 506-6900 (TELEPHONE NUMBER)

MAILING ADDRESS: same as above

(if different)

703/506-6988

(FAX NUMBER)

RECEIVED

E-MAIL ADDRESS: [katieb@arleighburke.org](mailto:katieb@arleighburke.org) WEB ADDRESS: [www.vinsonhall.org](http://www.vinsonhall.org/)

VDH/OLC

ADMINISTRATOR OF

RECORD: Kath1yn Branch

IS ANY PART OF THE FACILITY LICENSED BY ANOTHER STATE AGENCY? YES NO □ NUMBER OF BEDS: 32

l lunl.>by ceui tl\at the11!,wye nam 1mcility,1$ in cwllJillllllco ffltb the1>rnvlsion1 of the Code of Virginia. 1950, an1en®<I, Title 32.l, Chapter *5,*

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icle2,Rigfits and RCl!{lOnsibilities ofPatients in Nursing HO!l;les,

kM -- -

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Gi\,\ fl RF OF, i\llNLTRATOR/CHIEF OFFICER) ('\ursing llorne Administrator's Certificate !\umber)

1. 1ditioned Certificate of Public Need for Indigent and Specialty Care: I hereby certify that the facility named on this application is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article I, Section 32.1-102.C. The facility has reviewed its status regarding Certificates of Public Need issued to it, and has determined that:

D YES 0 NO I. Conditioned certificates for indigent or specialized care are applicable to the nursing facility.

1. YES 0 NO 2. Conditioned certificates for indigent or specializt,'(f care are applicable *to* this nursing facility and the nursing facility meets the requirements of the cc1tificates. (If "NO" to #2, attach a letter of explanation.

11're•by certify that the infonnation contained in the Apphcat10n for License Renewal 1s, lo the best of my knowledge, accurate and true.

|  |  |  |  |
| --- | --- | --- | --- |
| - \_ --- | \_ | .. | **10/02/2015** |
| (S (;',A I LIRE OF fHfl:"i'ISTfUTOR;CHIEF OFFH'ER) |  |  | (I},.\ IE {H C<HIPLETED) |

**N ICE: ,A·LfSJ'.fNG.OF L 1(:ENSEQ ROOMS ANO NUMBER OF BEDS PER ROOM MUST ACCOMPANY.THIS APPLICATION. PLEASE SIGN BE OWTOJNDICATETHATVOUHAVE,JTrCHIU>THELISTJNO.**

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2 OF 10

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LICENSE FEES

NURSING IIOME APPLICA IION

The application must be accompanied by a money order, bank or teller check, or certified check in the amount of renewal fee payable to the Virginia Department of Health. NO CASH WILL BE ACCEPTED.

SERVICE CHARGE ACCORING TO THE NUMBER OF BEDS: (CHECK ONE)

0 - 50 BEDS $75.00

0 51- 333 BEDS ............................................$ 1.50 {PER BED}

0 334 - BEDS AND OVER $500.00

MAKE CHECK OR MONEY ORDER

Payable to:

VIRGINIA DEPARTMENT OF HEALTH

MAIL TO:

VIRGINIA DEPARTMENT OF HEALTH OFFICE OF LICENSURE AND CERTIFICATION 9960 MAYLAND DRIVE, SUITE 401

RICHMOND, VIRGINIA 23233

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NURSING IIOME Al'l'LICA TION

**VIRGINIA STATE DEPARTMENT OF HEALTH APPLICATION FOR NURSING HOME LICENSE**

In accordance with the provisions of Chapter 5, Article I, Title 32.1, Code of Virginia of 1950, all non-federal medical and nursing facilities desiring license as

a nursing home in Virginia must submit the following information to the Virginia Department of Health.

ANY CHANGES DURING THE YEAR WHICH WOULD AFFECT THE ACCURACY OF THE FOLLOWING INFORMATION MUST BE REPORTED PROMPTLY, IN WRITING, TO THE VIRIGNlA DEPARTMENT OF HEALTH.

AP,LICATION R£QIJEm-'t::D J,1)R': ((:ffECK ON!) QU&lffED l!,FF£<1TIVE DA : 01/01/2016

(month/day/year)

[8l ANNUAL RENEWAL FOR CALENDER YEAR 2016

□

INITIAL LICENSE TO OPERATE A NURSING HOME CHANGES IN LICENSED BED CAPACITY

□

□

CHANGES IN OWNERSHIP OR OPERATOR

NAME OF FACILITY: Arleigh Burke Pavilion

PHYSICAL ADDRESS: 1739 Kirby Road (NUMBER & STREET)

CITY OR TOWN: McLean, VA 22101

CITY, STATE & ZIP CODE

COUNTY: Fairfax

(703) 506-6900

(TELEPHONE NUMBER)

MAILING ADDRESS: same as above

(if different)

703/506-6988

(FAX NUMBER)

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E-MAIL ADDRESS: katieb@)arleighburke.org WEB ADDRESS: [www.vinsonhall.org](http://www.vinsonhall.org/)

VDH/OLC

ADMINISTRATOR OF

RECORD: Kathryn Branch

IS ANY PART OF THE FACILITY LICENSED BY ANOTHER STATE AGENCY? YES NO O NUMBER OF BEDS: 32

1. h 'l't>by certify tJuu th aboX¢nam ,l facility is(n t1Wtt JJ1lt'ii:c with the p'lyyi11iqJ11tofthe COl:lc ofVirginJa; l.9$0, as animi 1'itlc 32J, Chapter *.5,*

A!icle 2, Rights and RC!ifl()nslbllitiCII of Patients in Nursirlg: Homes,

*i* i:,,Mr i,f; **>iC'1?,i,},f,;0&)1,f1Crn)** -----· { s gO! ;Administrator's Certificate l'\umbcr)

C nditioned Certificate of Public Need for Indigent and Specialty Care: I hereby certify that the facility named on this application is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article I, Section 32.1-102.C. The facility has reviewed its status regarding Certificates of Public Need issued to it, and has determined that:

DYES t8l NO I. Conditioned certificates for indigent or specialized care are applicable to the nursing facility.

D YES t8l NO 2. Conditioned certificates for indigent or specialized care are applicable to this nursing facility and the nursing facility meets the requirements of the ce1tificatcs. (lf"NO" to #2, attach a letter of explanation.

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**N JCE: A LISTING OF LICENSED ROOMS AND NUMBER OF BEDS PER ROOM MUST ACCOMPANY THIS APPLICATION. PLEASE SIGN HE OWTOINDICATETHATVOU HAV ATI'.CH.F.DTHELISTING.**

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2 OF 10

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LICENSE FEES

NURSING IIOME APPLICA IION

The application must be accompanied by a money order, bank or teller check, or certified check in the amount of renewal fee payable to the Virginia Department of Health. NO CASH WILL BE ACCEPTED.

SERVICE CHARGE ACCORING TO THE NUMBER OF BEDS: (CHECK ONE)

0 - 50 BEDS $75.00

0 51 - 333 BEDS .............................................$ 1.50 {PER BED}

0 334 - BEDS AND OVER $500.00

MAKE CHECK OR MONEY ORDER

Payable to:

VIRGINIA DEPARTMENT OF HEALTH

MAIL TO:

VIRGINIA DEPARTMENT OF HEALTH OFFICE OF LICENSURE AND CERTIFICATION 9960 MAYLAND DRIVE, SUITE 401

RICHMOND, VIRGINIA 23233

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NURSING HOME i\PPL!Ci\TION

LICENSING CLASSIFICATION OF NURISNG HOME FACILITIES AND BED CAPACITY BY SERVICE

**CURRENT BED**

**TYPES OF BEDS BY LICENSE CLASSIFICATION CAPACITY**

**LICENSED BEDS REQUESTED**

**TOTAL BED CAPACITY**

(Excluding Day Care)

Number of Beds Certified for Medicare Only (Title 18)

**FOR OFFICE USE ONLY**

Total Licensed Beds Approved

Date

Number of Beds Certified for Medicare/Medicaid

(Title I 8/19) *Q*

Number of Beds Certified for Medicaid only

(Title 19) *Q*

Number of Non-certified beds (Exclude Adult Residential beds)

Other beds (specify, i.e. Adult Residential

**SPECIFY TYPE OF BEDS**

Do you have a Nurse Aide training program on your premises? ...........................................

If yes, is it a certified Nursing Assistant Program approved by the Board of Nursing? ............

Adult Day Care facilities - Number of accommodations ....................................................

Child Day Care facilities - Number of accommodations ....................................................

Are the day care facilities required to be licensed by the Department of Social Services? ..........

1. Name of Director of Nursing Service: Hawa Lamin-Sidigue, RN 1/1
2. Name ofln-Service Training Director: Joanne Burke, RN
3. Name of Social Services Director: .Jennifer Price, BSW *r*
4. Name of Activities Director: Jared Jordan *J*
5. Name of Food Services Supervisor: Wendell McPherson
6. Name and address of Medical Director/Advisory Physician(s): Dr. Richard J. Hart, Jr. 6400 Arlington Blvd. Suite 940 Falls Church, VA 22042
7. Name and address of Dietary Consultant: Debra S. Fischer, RD, LD 8506 Sundale Dr. Silver Spring, MD 20901

YES ONO [2J YES NO 000000000000000

□ □

000000000000000

□

YES NO 0

1. Name and address of Pharmacy Consultant: Omnicare 1572 East Parham Road Richmond, VA 23228
2. Name and address of Physical Therapy Consultant: Rehab Management Inc. 1 Park West Circle #108 Midlothian, VA 23114
3. Name and address of Dental Consultant: **Dr.** Robert Mantoni 8757 Georgia Ave, Suite 530 Silver Spring, MD 20910

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NURSING HOME APPI.ICATION

**SURVEY of Long-Term Care Facilities with Shared Resources**

NURSING FACILITY NAME: Arleigh Burke Pavilion

ASSISTED LIVING FACILITY NAME: Arleigh Burke Pavilion

NUMBER OF ASSISTED LIVING FACILITY BEDS: 32

State Iicensure laws and regulation do not prohibit the integration or sharing of services/areas within nursing facility/assisted living arrangements. However, providers must demonstrate compliance with all relevant licensure regulations regarding full time staffing and facility environmental requirements. Providers arc obligated to assure that staffing assignments and shared services are sufficient to meet the assessed needs of all residents and the applicable regulations for each type of facility license. Please complete the questions below addressing sharing of staff, services and

1. Are residents of the 2 facilities in kRl the same building D separate buildings, same campus

D same wing D different wing kRl other: upper level is nursing. lower level is assisted

living

1. What services/areas are commonly shared?

Direct care D Administrative kRl Housekeeping kRl Food service/dietary l3J

Other: maintenance

1. What staff positions are shared and what is the frequency of duties shared?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Duties** | **No. of Staff** | **No. of**  **Shared Staff** | **Frequency**  **Daily Weekly** | **Duties** | **No. of Staff** | | **No. of Shared**  **Staff** | | **Frequency Daily Weekly** |
| **Direct Care Staff** | 0 | 0 | **0 0** | **Housekeeping** | 7 | | 7 | | **yes yes** |
| **Administrative Staff** |  |  |  | **Food/service Dietary** | **10** | | 10 | | **yes yes** |
| **Other: maintenance services entire building** | | |  | | **3** | I | 3 | I **yes yes** | |
| **laundrv services entire buildilw:** | | |

1. How are the Administrator duties conducted? Separate for each facility? Yes l3J No 0

If no, there must be an Assistant Administrator. Describe how the duties are delegated and how the Administrator is kept informed.

**Duties, delegated and how administrator is informed**

**The nursing unit and assisted living unit have their own dedicated nursing staff.**

**The NHA provides financial, business and contract oversight and directs support services through department managers for the entire building.**

**Morning meetings are held**

**with clinical staff and the Administrator for proper support when needed.**

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NURSING HOME APPLICATION

**OWNERSHIP AND OPERATION OF NURSING HOME**

In accordance with the provisions of Chapter 5, Article I, Title 32.1 Code of Virginia 1950, all non-federal facilities desiring licensure as a nursing home in Virginia must annually submit the following information to the Virginia Department of Health. The application for renewal of license will not he accepted unless **ALL** of the following information is appropriately completed.

**ANY CHANGES DURING THE YEAR WHICH WOULD AFFECT THE ACCURACY OF THE FOLLOWING INFORMATION MUST**

BE **PROMPTLEY REPORTED, IN WRITING, TO THE VIRGINIA DEPARTMENT OF HEALTH.**

FACILITY BUSINESS NAME: Arlci!!.h Burke Pavili. D

LE(;,\L :\A\lE OFTHEOPERATOR: Vinson Hall, I.LC

OPER\T(rn:s Bl.JSJ'\ESS ADORES: ! 739 Kirby Road

\lcLl'llll, \'A 22 IOI

(City or Town) (State) (Zip Code)

OPEIL\TOR'S TELEPIIO"iE :\U\IBER: (703) 506-6900

(include area code)

FA\. Nl:\lBlW.: 703/ 506-6988

(includ1; area code)

**TYPE OF OWNERSHIP AND CONTROL**

Is the facility operated by the owner of tlw building'! YES C8J 'iO D

If the facility IS owner-operated, complete only Column A.

If the facility IS NOT operated by the owner, complete both Column A and Column B.

(A)

OWNER

(B)

OPERATOR

□ □□

### □ □

□

□

□

STATE OR LOCAL GOVERNMENT:

State County City(ies)

Multijurisdictional Hospital District/Authority

NON-PROFIT:

Church Related

Non-Profit Corporation Other Non-Profit

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**PROPRIETARY:**

Single Proprietary Partnership Corporation

□ □

□ □

Limited Liability Corporation

*VDHJOLC*

ls there any person other than those listed on this form (owner, operator, administrator of record) who is authorized to make administrative management decisions regarding the facility? YES **NO** D

If yes, please identify the person and their relationship to the facility Michael Hendee, COO

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NURSING HOME APPLICATION

**INFORMATION REQUIRED ON THE OPERATOR/MANAGER OF THE FACILITY**

Name(s) and address(es) of the officers of the governing body. President/Chairman VADM John Cotton

4739 North 32nd Street Arlington, VA 22207 Vice President/ChairmanW. Mark Skinner

513 W Broad Street.Falls Church, VA 22046

Secretary CAPT W. Scott Slocum

2604 Lakevale Drive Vienna, VA 22181

Treasurer RADM William Morris

639 North Armistead Street Alexandria, VA 22312

If any officer, director, trustee or any member of the governing body or any other individual, partnership, association, trust, corporation, or other legal or commercial entity owns, holds or has a financial interest of five (5) percent of more in the operating/management entity, list the name and percentages of ownership below:

NAME OWNERSHIP PERCENTAGE

If the operator/manager has a lease or management agreement with the legal entity or individual who owns the physical plant/buildings list the name and the address of the owner.

(Name)

(Address)

If the operator/manager has a lease or management agreement with a legal entity or individual who is not the owner of the physical plant/buildings list the name and address of the lesser.

(Name)

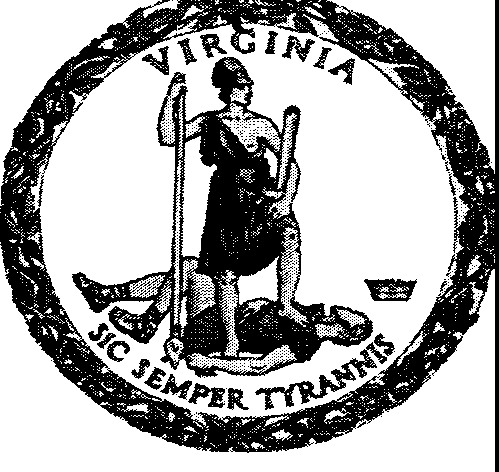
(Address)

If the operator/manager has a lease or management agreement with an owner or a lesser, does the owner or the lesser have a five (5) percent or more ownership interest in the legal entity that operates/manages the facility?

YES ONO 0

8 OF 10

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**Commonwealth of Virginia Virginia Department of Health**

Nursing Home License Number: **NH2480**

*In accordance with the provisions of Title 32.1. Chapter 5, Article 1, of the Code of Virginia 1950, as amended.*

**Vinson Hall, LLC**

(Operator)

is Authorized to Operate,

**Arleigh Burke Pavilion**

(Name of Organization)

a Nursing Home, located at:

**1739 Kirby Road, McLean, Virginia 22101**

Approved Capacity **49** Beds Expiration **12/31/2019**

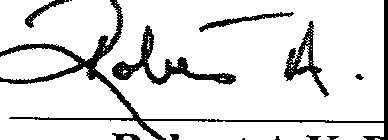
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*tiZ,*

1 Oliver, M.D. M.A.

State Health Commissioner

 *-"'--,*"'3D

Ro'bert A.K. Payne,':J.D. i,irector

Office of Licensure & Certification



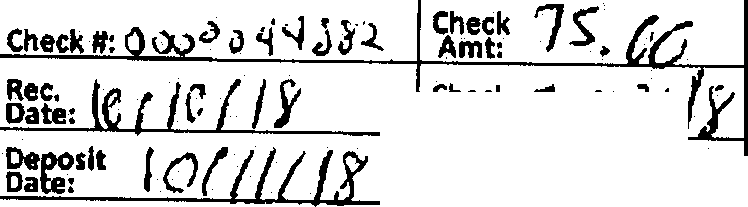
Nursing Home Application

Virginia Department of Health Application for Nursing Home License

In accordance with the provisions of Chapter S, Artlcle 1, Title 32,1, Code of Virginia of 19S0, all non-federal medical and nursing facilities desiring license as a nursing home In Virginia must submit the following Information to the Virginia Department of Health,

Any changes during the year, which wouJd affect the awurac;y of the followlng Information, must be reported promptlY, In

writln1, to the Virginia Department of Health,

Application for: (check one) IZ!Annual Renewal for Calendar Year

□

|  |  |  |
| --- | --- | --- |
| FOR OLC **USE ONLY** | | |
|  | | Check *c1 )* "\ *}/* •  Date: f |
|  |  | TI ketll: *l{JJ 331/* |

01nltlal License to Operate a Nursing Home

□

changes In Licensed Bed Capacity/Bed Change changes in ownership or Operator

Effective Date: 01/01/2019

Name of Facility (Doing Business As name): Arleigh Burke Pavilion Facility Physical Address: 1739 **Kirby Road**

(Additional space If needed)

City Or Town: Mclean State: VA Zip Code: 22101

County: Fairfax

Telephone Number with Area Code: 703-506-6900 Fax Number: 703-506-6988

Mailing Address: Same as above

Facility Web Address: [www.vlnsonhall.org](http://www.vlnsonhall.org/)

Name of Administrator of Record: Beth K Lwln / Administrator Email Address: *I* wit'\ *(SJ\_ \J ,'f\Scj., "o\_* //, *()*

b *lj*

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If the facility Is Medicare/Medicaid certified, has the facility registered for ePOC? r8J YES D NO D NOT Certified

If "YES," enter:

Date Registered: 7/20/2018

Name of Registered User: Beth Lwin

I hereby ce that the above named facility Is In compliance with the provisions of the Code of Virginia, 1950, as amended, Title ter S, Article 2, RI ts an Responslbllities of Patients In Nursing Homes.



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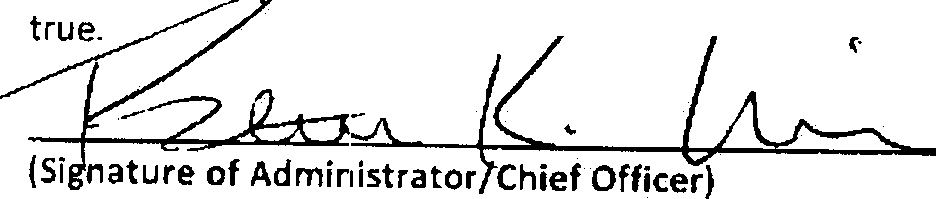
**1701002733**

(Nursing Home Administrator's License Number)

Conditioned Certificate of Public Need for Indigent and Specialty Care: I hereby certify that the facility named on this application is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article 1, Section 32.1-102,C, The facility has reviewed its status regarding Certificates of Public Need Issued to it, and has determined that:

1. Conditioned certificates for indigent or specialized care are applicable to the nursing facility. DYES [gl NO
2. If conditioned certificates for indigent or specialized care are applicable to this nursing facility, does the nursing facility meet the requirements of the certificates? DYES D NO (If "NO," attach a letter of explanation)

that the information contai ed in the Application for License Renewal is, to the best of my knowledge, accurate and



10-2-2017

(Date Completed)

5 of 14 10/02/2018

Nursing Home Application

Licensing Classification of Nursing Home Facilities and Bed Capacity by Service

Types of Beds by License Classlflcatlon Bed Capacity

Licensed Beds Requested

FOR OFFICE USE

ONLY

TotalfcrLicenseddBeds

*IOI/fl If*

Date

Total Bed Capacity (Specify Bed Types excluding Day Care)

Number of Beds Certified for Medicare Only (Title 18)

Number of Beds Certified for Medicare/Medicaid (Title 18/19)

Number of Beds Certified for Medicaid only (Title 19)

Number of Non-certified beds (Exclude Adult Residential beds)

**\*\*PLEASE INCLUDE FLOORPLAN OF FACILITY\*\***

Does the facility have a specialized unit? 0 YES t8J NO If yes, specify the type of specialized unit and number of beds (i.e. secured unit, ventilator unit, etc.)?

Type of Unit Number of beds

Does the facility have a Nurse Aide training program on your premises?

If yes, Is It a certified Nursing Assistant Program approved by the Board of Nursing?

□**YES** i:gj NO

□YES ONO

* 1. Name of Director of Nursing Service: Hawa Lamin-Sidlguie, RN, MSN
  2. Name of In-Service Training Director: Joanne Burke, RN-BC
  3. Name of Social Services Director: Terrell Tims
  4. Name of Activities Director: Amy Bian
  5. Name of Food Services Supervisor: Lemont Jolley
  6. Name of Medical Director/Advisory Physician(s): Dr. Nadeem Qazi
  7. Name of Dietarv Consultant: Monica Maroyka
  8. Name of Pharmacy Consultant:
  9. Name of Physical Therapy Consultant: Select Rehap
  10. Name of Dental Consultant: Dr. Mantoni

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Start Date: 05/12/14 Start Date: 04/27/06 Start Date: 01/07/16 Start Date: 05/02/18 Start Date: 04/20/16 Start Date: 08/07/17 Start Date: 11/01/17 Start Date: 04/01/11 Start Date: 02/29/16 Start Date: 07/14/15

6 of 14

10/02/2018

Survey of Long-Term Care Facilities

Nursing Home Application

Facility Name (Doing Business As name): Arleigh Burke Pavilion (Please make sure the Facility Name is spelled the same as on page 5)

Is any part of the facility licensed by another state agency? YES [8J NO D If yes, enter the number of beds: 32 Assisted Living If yes, specify the type of beds (i.e. Adult Resldentlal)

Does the faclllty have Adult Day Care facilitles? YES D NO [8] If yes, enter the number of accommodations: Does the facility have Child Day Care facilities? YES D NO [8J If yes, enter the number of accommodations: If yes, are the day care facilities required to be licensed by the Department of Social Services? YES D NOD

Does the facility share resources with an Assisted Living Facility? YES [8] NO D If yes, complete the following section: Assisted Living Facility Name: Arlelgh Burke Pavilion

Number of Assisted Living Facility Beds: 32

State licensure laws and regulation do not prohibit the Integration or sharing of services/areas within nursing faclllty/assisted living arrangements. However. providers must demonstrate compliance with all relevant licensure regulations regarding full time staffing and facility environmental requirements. Providers are obligated to assure that staffing assignments and shared services are sufficient to meet the assessed needs of all residents and the appllcable regulations for each type of faclllty license. Please complete the questions below addressing sharing of staff, services, and areas.

1. Are residents of the two facilities In:

D Same wing D Different wing,

1. What services/areas are commonly shared?

D Direct care, Administrative,

Other: Maintenance

[8J Same building, Oseparate buildings, same campus, [8:lother: Upper Level Is Nursing Home, lower level is Assisted Living

[8JHousekeeping, 1:8'.J Food service/dietary,

3• What staff pos1t1ons areshared and

w at 1st *e*frequency of d.ut1es **s**h**are**d?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Duties | No.of Staff | No.of Shared Staff | Frequency Dally or Weekly | Duties | No.of Staff | No.of Shared Staff | Frequency Dally or Weekly |
| Direct Care  Staff | 0 | 0 | 0 | Housekeeping | 7 | 7 | daily |
| Administrative  Staff | 5 | 5 | daily | Food/service Dietary | 10 | 10 | daily |
| Other: | | | | | | | |

1. How are the Administrator duties conducted? Separate for each facility? YES D NO. If no, there must be an Assistant Administrator. Describe how the duties are delegated and how the Administrator is kept Informed.

Enter duties delegated

The nursing unit and assisted living unit have their own dedicated staff, the NHA provides financial, business and contract oversight and directs support services through department managers for the entire building. Morning meetings are held with Clinical Staff and the Administrator to provide support when needed.

Enter how Administrator is Informed

Morning meetings are held with Clinical Staff and the Administrator for proper support when needed

Is the facility part of a CCRC? [8J YES D NO If yes, complete the following section:

* 1. How many beds are in the CCRC? 492
  2. How many Life Care Contract holders are In NON nursing home **beds?** 0 n/a not a life care facllftyA

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10/02/2018

Nursing Home Application

Ownership and Operation of Nursing Home

Facility Name (Doing Business As name): Arleigh Burke Pavilion (Please make sure the Facility Name is spelled the same as on page 5)

Legal name of the Operator of the facility: Vinson Hall, LLC Operator's physical address: 1739 Kirby Road

(Additional space If needed)

City or Town: McLean State: VA, Operator Telephone Number with Area Code: 703-506-6900

Zip Code: 22101

Fax with area code: 703-506-6988

Legal/Doing Busines.s As name of the Owner of the nursing home business: Vinson Hall, LLC Owner's physical address: 1739 Kirby Road

(Additional space if needed)

City or Town: McLean 

Is the facility operated by the owner of the building? YES O NO Is the facility owned by the owner of the building? YES O NO

Zip Code: 22101

Type of Ownership and Control

If the facility IS owner-operated, select ONE from Column A.

If the facility IS NOT operated by the owner, select ONE from Column A and ONE from Column B.

(A) **(B)**

OWNER OPERATOR

(of facility) (of faclllty)

□ □

□

□

State or Local Government:

State

County Clty(les)

□

□

□

Multljurisdictlonal

□

□ Hospital District/Authority

Non•Proflt:

□ □

Church Related

□

**Non-Profit** Corporation

* □ Other **Non-Profit**

Proprietary: Single Proprietary Partnership

□

□

□ □

□

□

Corporation

□

* Limited Liability Corporation

Is there any person other than those listed on this form (owner, operator, administrator of record) who is authorized to make administrative management decisions regarding the facility? YES D NO RECE \VED

If yes, please Identify the person and their relationship to the facility

Person's name and relationship to facility Libby Bush, CEO OC1 1 O 2018

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8 of 14

10/02/2018

Information Required on the Operator/Manager of the Facility

Nursing Home Application

Please enter the names and Physical addresses of the governing body. If the position Is vacant, please put "vacant." If more space Is needed, please attach additional pages to the back of the application

Name of President/Chair: Physical Address:

Name of Vice President: Physical Address:

Name of Secretary: Physical Address:

Name of Treasurer: Physical Address:

VADM **W. Mark** Skinner, USN(Retl

6251 Old Dominion Drive, McLean VA 22101

RADM Robert O Wray, USN(Ret)

6251 Old Dominion Drive, McLean VA 22101

RADM William R. Rowley, MC, USN(Ret)

6251 Old Dominion Drive, McLean VA 22101

CAPT W. Scott Slocum, USN (Ret)

6251 Old Dominion Drive, McLean VA 22101

If any officer, director, trustee or any member of the governing body or any other individual, partnership, association, trust, corporation, or other legal or commercial entity owns, holds or has a financial interest of five (5) percent of more In the operating/management entity, list the name and percentages of ownership below:

**OWNERSHIP PERCENTAGE**

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Are all remaining financial interests less than 5 percent? QVES ONO

If the operator/manager has a lease or management agreement with the legal entity or Individual who owns the physical plant/buildings, list the name and the address of the building owner.

Name of Building Owner: N/A Physical Address of Owner:

If the operator/manager has a lease or management agreement with a legal entity or lndlvldual who is not the owner of the physical plant/buildings, list the name and address of the lessor.

Name of Lessor: N/A

Physical Address of Lessor:

If the operator/manager has a lease or management agreement with an owner or a lesser, does the owner or the lessor have a five (5) percent or more ownership Interest In the legal entity that operates/manages the facility? DYES D NO

9of 14

10/02/2018

Enter Bed Listing Here

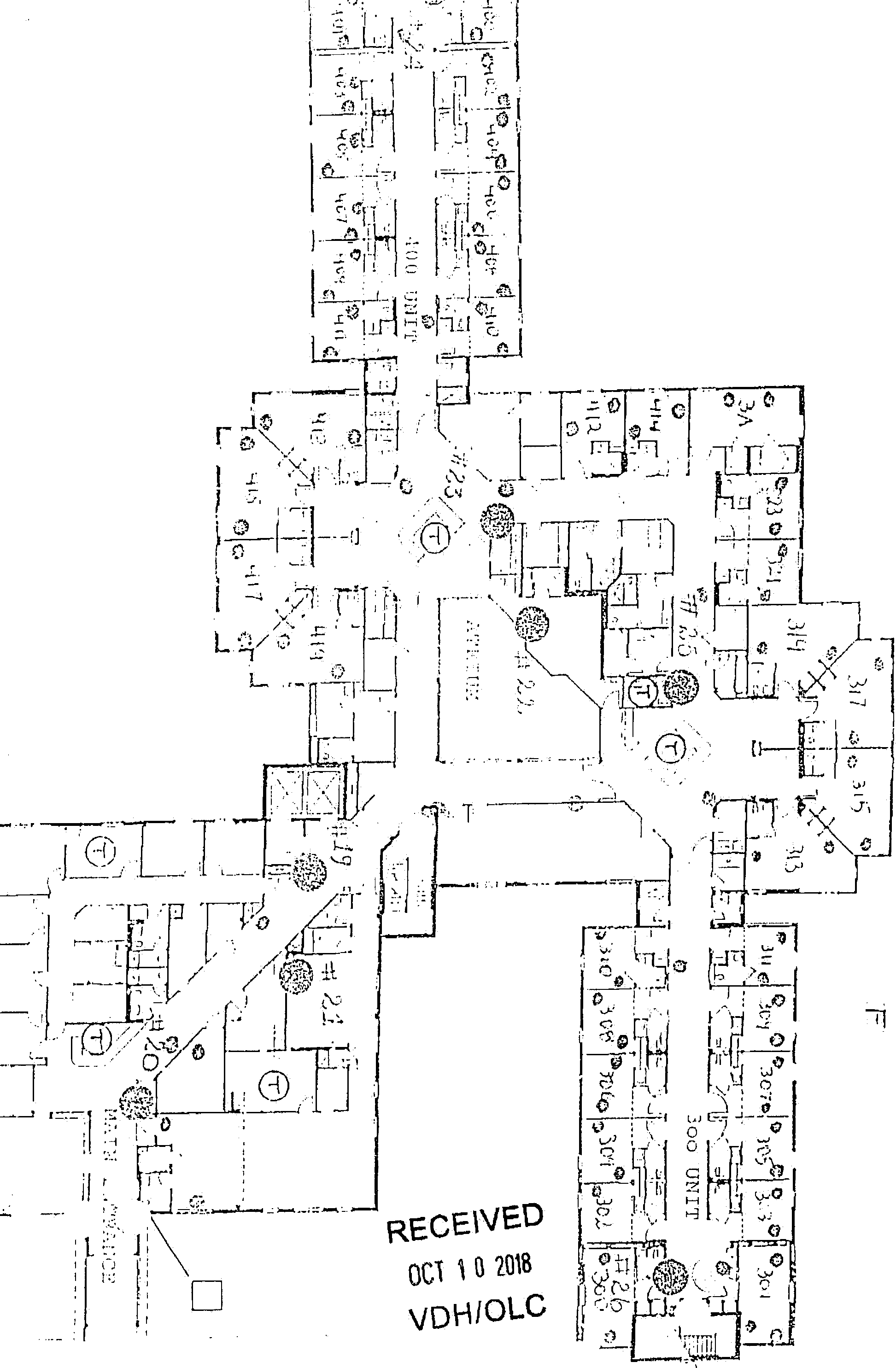
Nursing Home Application

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| Room No. | No.of  beds | Medicare  &  Medicaid | **Medi·** care Onlv | Medi- caid Onlv | Licensed Only | | Room No. | No. of  beds | Medicare & Medicaid | **Medi·**  care  Onlv | **Medi-** cald Only | Licensed Only |
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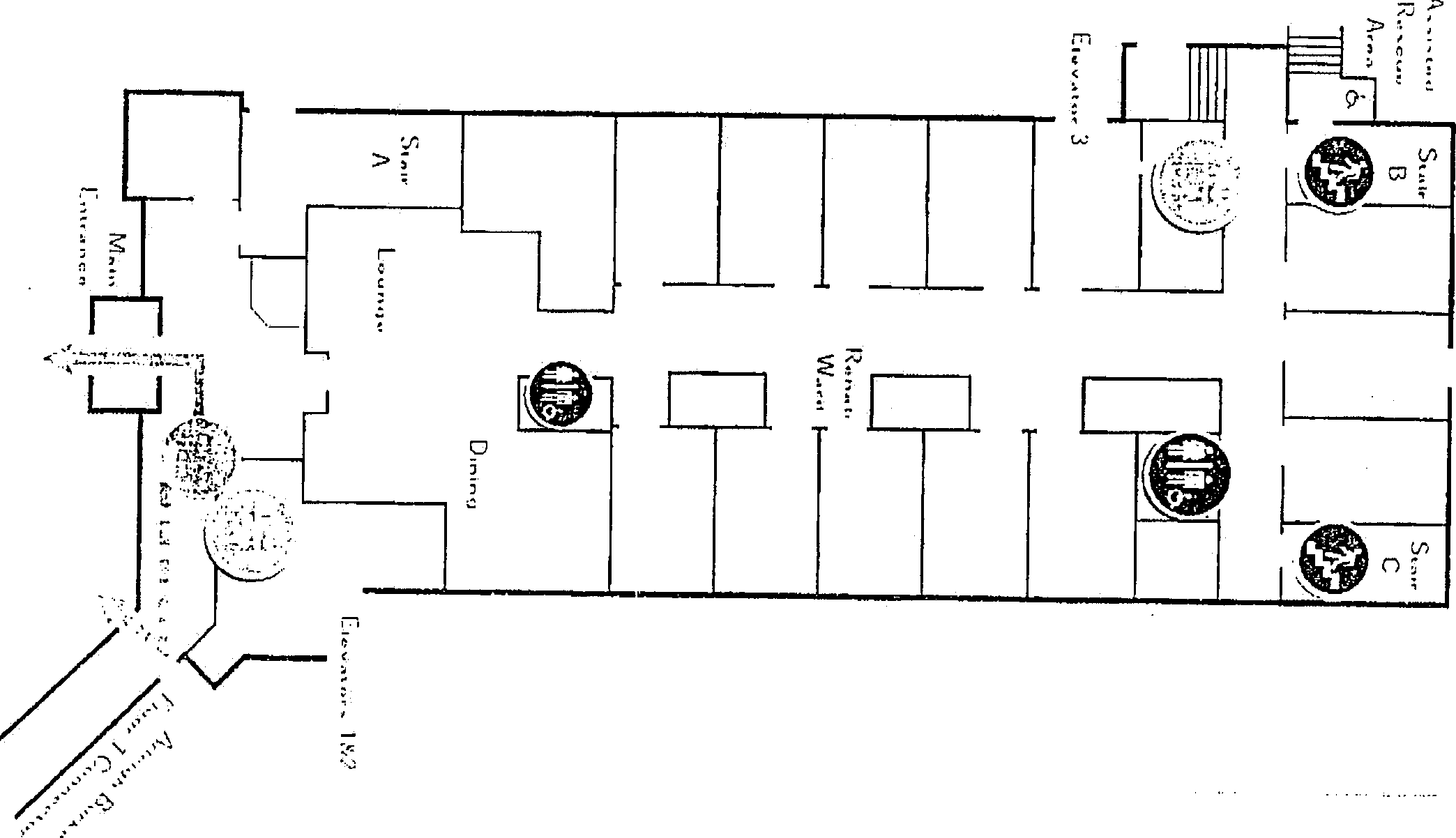
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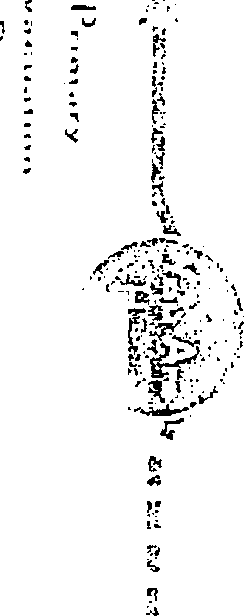
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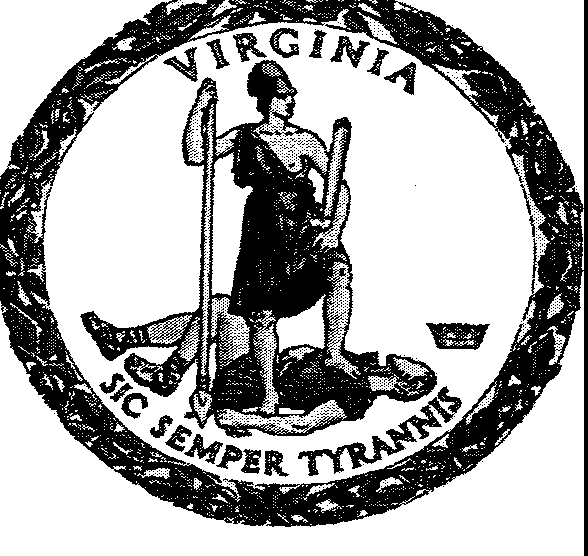
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**Commonwealth of Virginia Virginia Department of Health**

Nursing Home License Number: **NH2480**

*In accordance with the provisions of Title 32.1. Chapter 5, Article 1, of the Code of Virginia 1950, as amended.*

**Vinson Hall, LLC**

(Operator)

**is Authorized to Operate,**

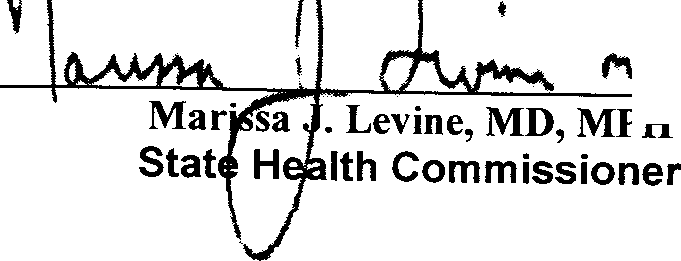
**Arleigh Burke Pavilion**

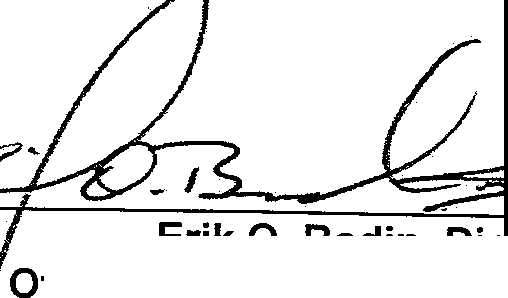
(Name of Organization)

**a Nursing Home, located at:**

**1739 Kirby Road, McLean, Virginia 22101**

Approved Capacity **49** Beds Expiration **12/31/2017**

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Erik 0. Bodin, Director Office of Licensure and Certification

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Nursing Home Application

Virginia Department of Health Application for Nursing Home License

In accordance with the provisions of Chapter 5, Article 1, Title 32.1, Code of Virginia of 1950, all non-federal medical and nursing facilities desiring license as a nursing home in Virginia must submit the following information to the Virginia Department of Health.

Any changes during the year, which would affect the accuracy of the following Information, must be reported promptly. in writing. to the Virginia Department of Health.

Application for: (check one)

lg) Annual Renewal for Calendar Year

D Initial License to Operate a Nursing Home

D Changes in Licensed Bed Capacity/Bed Change

D Changes in Ownership or Operator

Effective Date: 01/01/2017

Name of Facility (Doing Business As name): Arieigh Burke Pavilion Facility Physical Address: 1739 Kirby Road

(Additional space if needed)

City Or Town: McLean State: VA Zip Code: 22101

County: Fairfax,

Telephone Number with Area Code: 7035066900 Fax Number: 7035066988

Mailing Address: 1739 Kirby Road McLean, VA 22101 Facility E-Mail Address: [katieb@vinsonhall.org](mailto:katieb@vinsonhall.org)

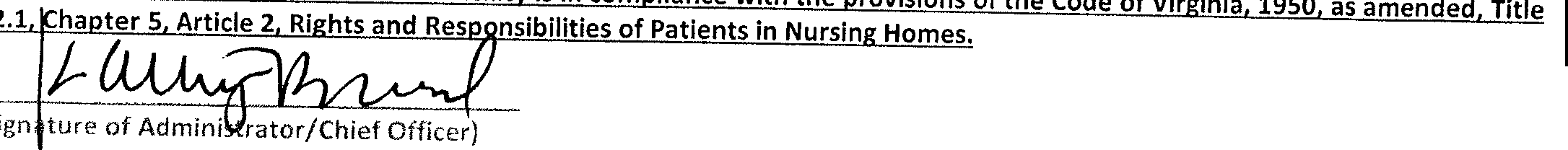
Facility Web Address: [www.vinsonhail.org](http://www.vinsonhail.org/)

Name of Administrator of Record: Kathryn M. Branch

If the facility is Medicare/Medicaid certified, has the facility registered for ePOC? YES NO O NOT Certified0

If "YES," enter date registered and name of ePOC user. 04/28/16 Kathryn Branch

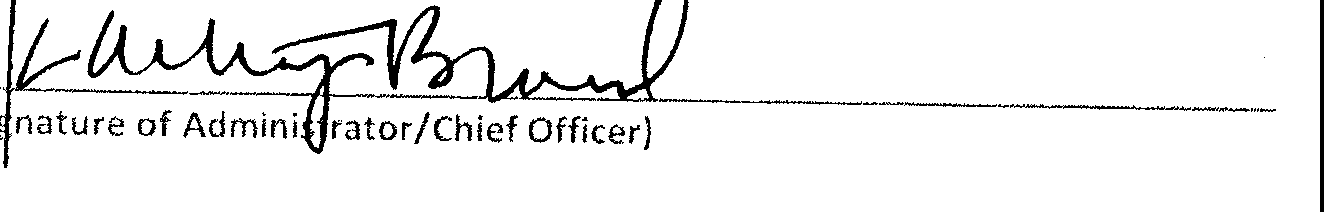
(Nursing Home Administrator's License Number)



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Conditioned Certificate of Public Need for Indigent and Specialty Care: I hereby certify that the facility named on this application is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article 1, Section 32.1-102.C. The facility has reviewed its status regarding Certificates of Public Need issued to it, and has determined that:

1. Conditioned certificates for indigent or specialized care are applicable to the nursing facility.0 YES lg) NO
2. If conditioned certificates for indigent or specialized care are applicable to this nursing facility, does the nursing facility meet the requirements of the certificates? 0 YES O NO (If "NO," attach a letter of explanation)

I hereby certify that the information contained in the Application for License Renewal is, to the best of my knowledge, accurate and

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Nursing Home Application

**Licensing Classification of Nursing Home Facilities and Bed Capacity by Service**

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**Types of Beds by License Classification Bed Capacity**



**Licensed Beds Requested**

**Total Bed Capacity (Specify Bed Types excluding Day Care)**

**FOR OFFICE USE ONLY**

Total Licensed Beds

Approved

Date

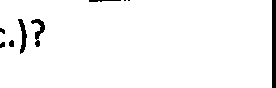
Number of Beds **Certified for** Medicare Only

**(Title 18)**

Number of Beds Certified for Medicare/Medicaid (Title 18/19}

Number of Beds Certified for Medicaid only (Title 19)

Number of Non-certified beds (Exclude Adult Residential beds)

Does the facility have a specialized unit?  If yes, specify the type of specialized unit and number of beds (i.e. secured unit, ventilator unit, etc.)?



Type of Unit Number of beds

□

Does the facility have a Nurse Aide training program on your premises?

If yes, is it a certified Nursing Assistant Program approved by the Board of Nursing?

□YES

YES



1. **Name of Director of Nursing Service:** Hawa Lamin-Sidique, RN, MSN
2. **Name of In-Service Training Director:** Joanne Burke, RN-BC

**c. Name of Social Services Director:** Terrell Timms

1. **Name of Activities Director:** Jocelyn Jackson
2. **Name of Food Services Supervisor:** Lemont Jolley
3. **Name of Medical Director/Advisory Physician(s):** Dr. Richard Hart
4. **Name of Dietary Consultant:** Debra Fischer
5. **Name of Pharmacy Consultant:** Omnicare
6. **Name of Physical Therapy Consultant:** Select Rehab
7. **Name of Dental Consultant:** Dr.Robert Mantoni

**Start Date:** 05/12/14 **Start Date:** 04/27/05 **Start Date:** 01/07/16 **Start Date:** 05/04/16 **Start Date:** 04/20/16 **Start Date:** 06/01/05 **Start Date:** 12/03/11 **Start Date:** 04/01/11 **Start Date:** 02/29/16 **Start Date:** 07/14/15

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**Survey of Long-Term Care Facilities**

Nursing Home Application

Facility Name (Doing Business As name): Arleigh Burke Pavilion

(Pir,;1 0• make sure the Facility Jame is speileci the same as on page 5)

Is any part of the facility licensed by another state agency? YES [8J NOD If yes, enter the number of beds: 32 If yes, specify the type of beds (i.e. Adult Residential) Assisted Living

Does the facility have Adult Day Care facilities? YES D NO [8J If yes, enter the number of accommodations: Does the facility have Child Day Care facilities? YES D NO [8J If yes, enter the number of accommodations: If yes, are the day care facilities required to be licensed by the Department of Social Services? DYES D NO

Does the facility share resources with an Assisted Living Facility? YES [8J NOD If yes, complete the following section: Assisted Living Facility Name: Arleigh Burke Pavilion

Number Of Assisted Living Facility Beds: 32

State licensure laws and regulation do not prohibit the integration or sharing of services/areas within nursing facility/assisted living arrangements. However, providers must demonstrate compliance with all relevant licensure regulations regarding full time staffing and facility environmental requirements. Providers are obligated to assure that staffing assignments and shared services are sufficient to meet the assessed needs of all residents and the applicable regulations for each type of facility license. Please complete the questions below addressing sharing of staff, services, and areas.

1. Are residents of the two facilities in:

0 Same wing D Different wing,

.r8J. Same building, 0 Separate buildings, same campus,

.l:8J. Other: upper level is nursing home. lower level is assisted living

1. What services/areas are commonly shared?

D Direct care, 0 Administrative, .l:8J. Housekeeping,

0 Other: maintenance

0 Food service/dietary,

1. What staff positions are shared and what is the frequency of duties shared?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Duties | No. of Staff | No. of Shared  Staff | Frequency  Daily or Weekly | Duties | No. of Staff | No. of Shared Staff | Frequency Daily or Weekly |
| Direct Care Staff | 0 | 0 | 0 | Housekeeping | 7 | 7 | daily |
| Administrative Staff | 5 | 5 | daily | Food/service Dietary | 10 | 10 | daily |
| Other: maintenance-3, 3, daily | | | | | | | |

1. How are the Administrator duties conducted? Separate for each facility? [8J YES D NO. If no, there must be an Assistant Administrator. Describe how the duties are delegated and how the Administrator is kept informed.

Enter duties delegated

The nursing unit and assisted living unit have their own dedicated nursing staff. The NHA provides financial. business and contract oversight and directs support services through department managers for the entire building. Morning meetings are held with clinical staff and the Administrator for proper support when needed.

Enter how Administrator is informed

Morning meetings are held with clinical and non-clincial department managers with the Administrator for proper support when needed.

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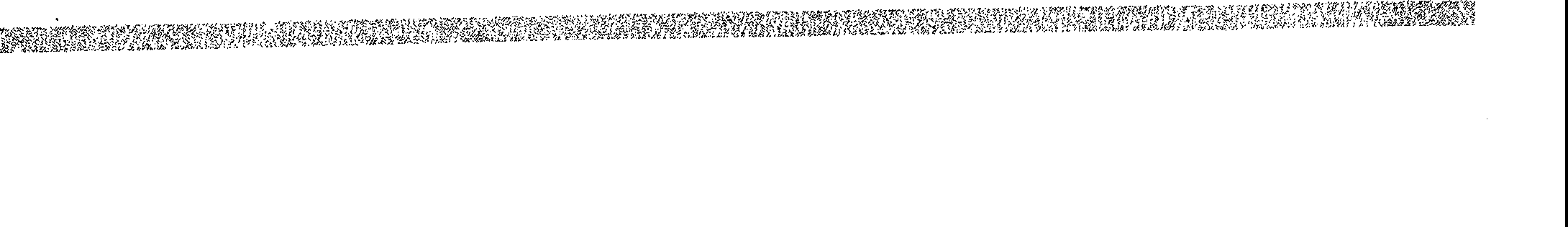


Is the facility part of a CCRC? YES [8J NOD If yes, complete the following section: , / , ***V***

1. How many beds are in the CCRC? 492 ***V<)L,*** *1 ,f '()*
2. How many Life Care Contract holders are in NON nursing home beds? 0 N/A not a life care community ***q*** *Va " 6*

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Ownership and Operation of Nursing Home

Nursing Home Application

Facility Name (Doing Business As name): !:.r.Leigh Burke Pavilion (PIE::ase make sure the Facility Name is spelled the same as on page 5)

legal name of the Operator of the facility: Vinson HalL. LLC Operator's physical address: 1739 l<irbv RQI!.U.

{Additional\_<;;\_pace\_if neededl -----····

Citvor Town: McLean Statt:. Y..t.,,

Op rator\_Tel hone\_Number with Area Code: 7035066900

li.Q. Cog J210l

Fax with area code: 7035066988

Legal/Doing Business As name of the Owner of the nursing home business: \_'{rnson Hall, .LS Owner's physical address: 1739 Kirby Hoad

LAdditional\_s.Illice ifneede\_dj \_

City\_orlown: McLean State\_: VA, ip\_Code: 22101

Is the facility operated by the owner of the building?

Is the facility owned by the owner of the building?

(gJ YES

(gJ YES

Type of Ownership and Control

If the facility owner-operated, select ONE from Column A.

If the facility IS NOT operated by the owner, select ONE from Column A and ONE from Column B.

1. (B)

OWNER OPERATOR

(of facility) (of facility)

State or Local Government:

□□ □

State County

City(ies)

□ □

Multijurisdictional

* □ Hospital District/ Authority

Non-Profit:

* □ Church Related

f2J Non-Profit Corporation□

* □ Other Non-Profit

Proprietary:

Single Proprietary Partnership

□ □

Corporation

□

* Limited Liability Corporation

**Is there any person other than those listed on this form (owner, operator, administrator of record) who is authorized to make administrative management decisions regarding the facility?** [2] **YES** D **NO**

**If yes, please identify the person and their relationship to the facility**

**Person's name and relationship to facility** Michael Hendee, Chief Operating Officer **RECE f VED**



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**Information Required on the Operator/Manager of the Facility**

Nursing Home Application

Please enter the names and Physical addresses of the governing body. If the position is vacant, please put "vacant." If more space is needed, please attach additional pages to the back of the application

Name of President/Chair: Physical Address:

Name of Vice President: Physical Address:

Name of Secretary: Physical Address :

Name of Treasurer: Physical Address :

VADM W. Mark Skinner, USN (Ret)

6251 Old Dominion Drive McLean, VA 22101

RADM Robert 0. Wray, USN (Ret)

6251Old Dominion Drive McLean, VA 22101

RADM Mark Lawton, JAGC, USN (Ret)

6251 Old Dominion Drive McLean, VA 22101

CAPT W. Scott Slocum, USN (Ret)

6251 Old Dominion Drive McLean, VA 22101

If any officer, director, trustee or any member of the governing body or any other individual, partnership, association, trust, corporation, or other legal or commercial entity owns, holds or has a financial interest of five (5) percent of more in the operating/management entity, list the name and percentages of ownership below:

OWNERSHIP PERCENTAGE

Are all remaining financial interests less than 5 percent? [] YES [] NO

If the operator/manager has a lease or management agreement with the legal entity or individual who owns the physical plant/buildings, list the name and the address of the building owner.

Name of Building Owner: N/A Physical Address of Owner:

If the operator/manager has a lease or management agreement with a legal entity or individual who is not the owner of the physical plant/buildings, list the name and address of the lessor.

Name of Lessor:

Physical Address of Lessor:

If the operator/manager has a lease or management agreement with an owner or a lesser, does the owner or the lessor have a five (5) percent or more ownership interest in the legal entity that operates/manages the fa...d[!tyJ. DYES D NO

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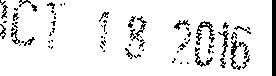
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**Enter Bed Listing Here**

Nursing Home Application

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| , .,\_,,\_  **Room No.** | | **No. of beds** | **Medicare**  &  **Medicaid** | **Medi- care Only** | **Medi-**  **caid Only** | **Li-**  **censed Only** | **Room No.** | **No. of beds** | **Medicare**  &  **Medicaid** | **Medi- care**  **Only** | **Medi- caid Only** | **Li- censed Only** |
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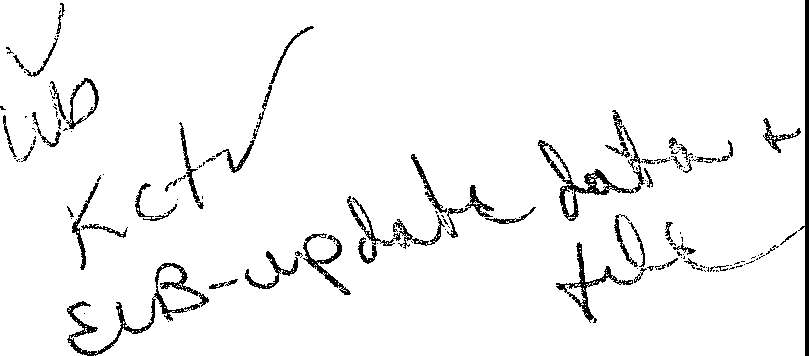
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August 24, 2017

Ms. Wietske Weigel-Delano Virginia Department of Health Office of Licensure and Certification 9960 Mayland Drive, Suite 401

Richmond, VA 23233

Re: Notification of Administrator Change for Arleigh Burke Pavilion Dear Ms. Weigel-Delano:

I am writing to notify the Office of Licensure and Certification of the change in Administrator for facility Arleigh Burke Pavilion. Effective August 21, 2017, Beth Lwin, license number 1701002733, replaced Michael Hendee, license numberl 701002614. Ms. Lwin's contact information is [bethl@vinsonhall.org](mailto:bethl@vinsonhall.org) or (703) 506-2124. If you have any questions please contact me directly at 703-538-2980 or michaelh(a),vinsonhall.org

Sincerely,

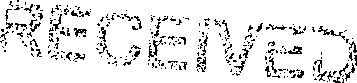
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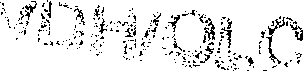
*--::? -----*

Michael N. Hendee Chief Operating Officer

**MNH**

aaa





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**Arleigh Burke Pavilion** - *l.,,irt«/11izi1(c.~ ffeal!bCiiit* • l-:CJ'J I,irb1· Road • :-lcLL"Ul, \',\22lOl • !-ll.l) 5116-69C1l L,, -r 1.1) 5(16-(,9:-\8

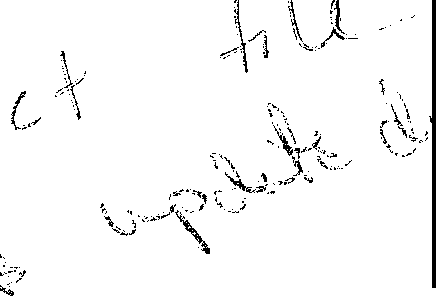
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www,insonhallotg





MAKING EVERY MOMENT COUNT WITH DIGNITY, FRIENDSHIP AND SECURITY

/

***.J***

**June 21, 2017 **

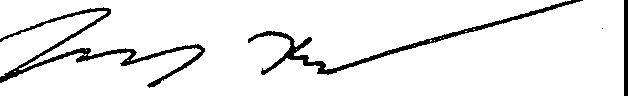
**Ms. Wietske Weigel-Delano Virginia Department of Health**

**Office of Licensure and Certification 9960 Mayland Drive, Suite 401**

**Richmond, VA 23233**

Re: Notification of Administrator Change Dear Ms. Delano:

I am writing to notify the Office of Licensure and Certification of the change in Administrator for Arleigh Burke Pavilion. Effective, June 16, 2017, Michael N. Hendee, license number 1701002614, will be the Acting Administrator replacing Kathryn Branch, license number 1701002069, due to her family moving out of state. If you have any additional questions, please contact me directly at 703-538-2980 or [michaelh@vinsonhall.org](mailto:michaelh@vinsonhall.org)

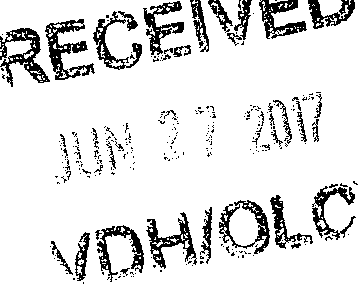
Sincerely,

Michael N. Hendee Chief Operating Officer

Vinson Hall Retirement Community

**MNH**

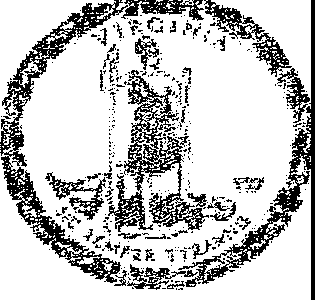
**aaa**



**Vmson** *Hall-I11d4x:11rlr11tlJ1i11g* • 6251 OklDominionDi:r.-e • i\fcl.e;u1., Vt\22101 • (703) 536--4344 (800)451-5l21 EL,(703) 538--2999 **Arleigh Burke Pavilion** -*/ L.:1i,11d Liizi{* o *Hm!th* G111,• 1739 Kirby Road • i\[cl.e;u1., VA 22lO1 • (703) 5(Xr69\XJ E1,, (703) 50Cr6988 **The Sylvestery** - *Dlme1111tufai.,t1tl1J1i1{g* • 1728 Kirby Road • i\kl.e;u1., *\,1\.* 22101 • 703 970-270) bx (703) 971)..2759

\VW\\Mnsonhall.org





Marissa **J.** Levine, MD, MPH, FAAFP State Health Commissioner

*COMMONWEALTH* ***of VIRGINIA***

*Department of Health*

Office of Licensure and Ce1iification **TYY 7-1-1 OR**

**1-800-828-1120**

9960 Mayland Drive, Suite 401

Henrico, Virginia 23233-1485

Fax (804) 527-4502

November 16, 2017

Ms. Beth Lwin, Administrator Arleigh Burke Pavilion

1739 Kirby Road

Mc Lean, VA 22101

RE: Arleigh Burke Pavilion Provider Number 495410

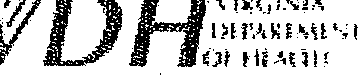
Dear Ms. Lwin:

An unannounced standard survey, ending November 15, 2017, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. No complaints were investigated during the survey.

**All** references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.



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***--,,,,,t'"tv·,v."tdh.*v rglrda ..g-0, 1**

Ms. Beth Lwin, Administrator November 16, 2017

Page 2

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of F), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Wietske G. Weigel-Delano, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

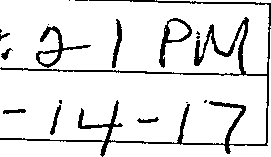
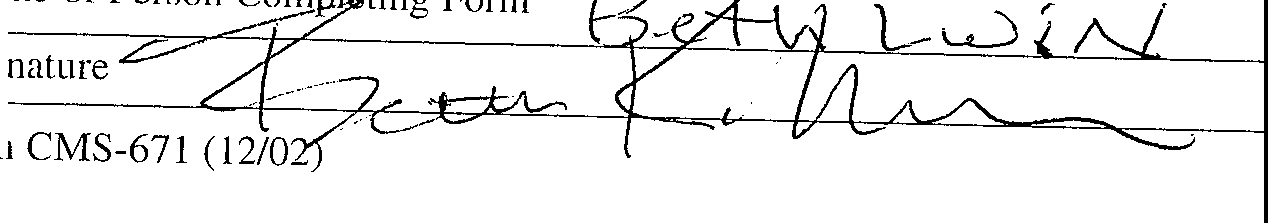
**The PoC will serve as the facility's allegation of compliance.** If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

**Following the receipt and review of your survey report,** please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at ["http://www.vdh.state.va.us/OLC/longtermcare/".](http://www.vdh.state.va.us/OLC/longtermcare/)

FACILITY STAFFING

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | A | | | | **B** | | | | | C | | | | | D | | | | |
|  | Tag  **Number** | **Services Provided** | | | | **Full-Time Staff (hours)**  g er | | | | | Part-Time Staff  **(hours)** | | | | | **Contract (hours)** | | | | |
| **1** | | 2 | 3 |
| **Administration** | F33 |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Physician Services | F34 | *'f-* | | N | L' |  |  | - |  |  |  |  |  |  |  |  |  |  |  |  |
| Medical Director | F35 | I | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 0 |
| Other Physician | F36 |  | |  |  |  |  |  |  |  |  |  |  | - |  |  |  |  | 1 | *1*  .f |
| Physician Extender | F37 | *---I* | | *N* | , |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| **Nursing Services** | F38 |  | | *(\{* | *,"\}* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| RN Director of Nurses | F39 | *I* | |  |  |  |  |  | *(*-*))* | *0* |  |  |  |  |  |  |  |  |  |  |
| Nurses with Admin. Duties | F40 |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Registered Nurses | F41 |  | |  |  |  |  |  | *0* | \ |  |  |  | *"'L{'* | ***C7*** |  |  |  |  |  |
| Licensed Practical/ Licensed Vocational Nurses | F42 |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  |  |  | *I* | ,4, | *p,* | **L/** |  |  |  |  | *cj* |  |  |  |  |  |
| Certified Nurse Aides | F43 |  | |  |  |  | .1- |  | 9 | *C:* |  |  |  | ;)- | L.'..I |  |  |  |  |  |
| Nurse Aides in Training | F44 |  | |  |  |  |  |  |  |  |  |  |  |  | I |  |  |  |  |  |
| Medication Aides/Technicians | F45 |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Pharmacists** | F46 | *----r* | | *r{* | *r--1* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Dietary Services** | F47 | *·j* | | *N* | N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dietitian | F48 | ( | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | *d-* | *A--* |
| Food Service Workers | F49 |  | |  |  |  | *)* | *0* | *:)\_.,* | **-;:I**  *-;* |  |  | I | ) *)* | *(o* |  |  |  |  |  |
| **Therapeutic Services** | F50 | *I* | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Occupational Therapists | F5l | V | | *l\l* | lv |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 9 |
| Occupational Therapy Assistants | F52 |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | *J* | *D* | *()* |
| Occupational Therapy Aides | F53 |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Physical Therapists | F54 | *''-I* | | *N* | *N* |  |  |  |  |  |  |  |  |  |  |  |  |  | 9 | k |
| Physical Therapists Assistants | *FSS* | *I* | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | *6*-*-* | *C* |
| Physical Therapy Aides | F56 |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Speech/Language Pathologist | F57 | \ ... |  | *N* | N |  |  |  |  |  |  |  |  |  |  |  |  |  | *!;'* | *IP* |
| Therapeutic Recreation Specialist | F58 | *11* | *t Al* | | *tJ* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Qualified Activities Professional | F59 | *\i* | | *tJ* | 1/V |  |  |  | t;,\ | 0 |  |  |  |  |  |  |  |  |  |  |
| Other Activities Staff | F60 | \ | *i* | *N* | *i\J* |  |  | *2---* | ;}- | ) |  |  |  | *\o* | I |  |  |  |  |  |
| Qualified Social Workers | F61 | ''½ | | A\ | itv |  |  |  |  | *[)* |  |  |  |  |  |  |  |  |  |  |
| Other Social Services | F62 | */"'-!* | | *N* | *N* |  |  |  | -- |  |  |  |  |  |  |  |  |  |  |  |
| **Dentists** | F63 | *'\J* | | i | *IV* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Podiatrists** | F64 | *!...j* | | *N* | *N* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Mental Health Services** | F65 | *s!.j"* | | *N* | *{\/* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Vocational Services** | F66 | *ti(* | | *I\[* | *rJ* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Clinical Laboratory Services** | F67 | ........,,. | | N | *f'J* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Diagnostic X-ray Services** | F68 | *{* |  | ***I\J*** | *tT\l* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Administration** & **Storage of Blood** | F69 | N | | *N* | *N* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Housekeeping Services** | F70 | \.... | | *N* | *N* |  |  |  |  |  |  |  |  |  |  |  |  | *VJ* | *0* | iO |
| **Other** | F71 | I | |  |  |  |  | ) | '7 | 2 |  |  |  |  |  |  |  |  |  |  |



Time

Date

DEPARTMENT OF HEALTH AND HUMK1'1" SERVICES

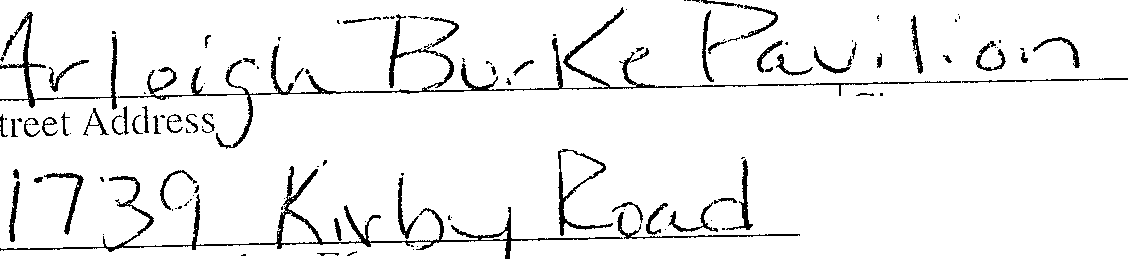
CENTERS FOR MEDICARE & MEDICAID SERVJCES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

**Standard Survey**

From: Fl [i]IJ CJ [.i][JJ To: F2 QJ[l] [JJG! uJ[J]

MM DD YY MM DD YY



|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Facility  Telephone Number: F6 |  | | | Provider Number  *I D* | | | | Fiscal Year Ending: F5  f2Jl6 B □ Jt)  MM DD YY | |
|  | City | | |  | County | State  VA | | Zip Code |
|  | | State/County Code: F7  J-90 | | | | State/Region Code: FS | | |

**Extended Survey**

From: F3 DD 0[] [JD To: F4 ll[J [][J DD

MM DD YY MM DD YY

A. F9 rOllJ

01 Skilled Nursing Facility (SNF) - Medicare Participation 02 Nursing Facility (NF) - Medicaid Participation

03 SNF/NF - Medicare/Medicaid

B. ls this facility hospital based? FI O Yes []

If yes, indicate Hospital Provider Number: Fl 1 [J[JDDDDD

Ownership: F12 **00** A

**For Profit**

01 Individual

**NonProfit**

04 Church Related

07 State

**Government**

10 City/County

1. Partnership
2. Corporation
3. Nonprofit Corporation
4. Other Nonprofit
5. County
6. City
7. Hospital District
8. Federal

Owned or leased by Multi-Facility Organization: Fl3 Yes ll No J;&\_

Name of Multi-Facility Organization: Fl4

Dedicated Special Care Units (show number of beds for all that apply)

*FIS* ODD AIDS F16 ODD Alzheimer's Disease

□□□ □□□

Fl7 Dialysis FIS Disabled Children/Young Adults

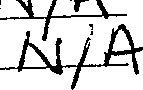
F19 DOD Head Trauma F20 ODD Hospice

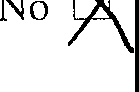
F21 DOD Huntington's Disease F22 ODD Ventilator/Respiratory Care F23 ODD Other Specialized Rehabilitation

Yes No □

|  |  |  |
| --- | --- | --- |
| Does the facility currently have an organized residents group? | F24 | Yes D No |
| Does the facility currently have an organized group of family members of residents? | F25 |  |
| Does the facility conduct experimental research? | F26 | Yes D N |
| Is the facility part of a continuing care retirement community (CCRC)? | F27 | Yesp( No 0 |

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the clate(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

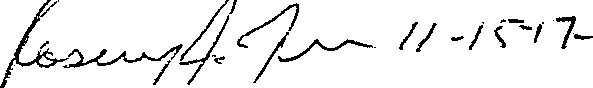
Waiver of seven clay RN requirement. Date: F28 DD DD DD Hours waived per week: F29  Waiver of 24 hr licensed nursing requirement. Date: F30 DD DD DD Hours waived per week: F3 l

MM DD YY

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program?

*/ it'.*

*j*

**Fo,m CMS 671 (12/02)** *L;t\_;o--*

*i I Iii ,II*

F32 Yes D

Ms. Beth Lwin, Administrator November 16, 2017

Page 4

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: ["http://www.vdh.virgi](http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20respon)n[ia.gov/OLC/Downloadables/docu ments/2011/pdf/LTC%20facility%20survey%20respon](http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20respon) se%20form.pdf". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

*L*

*cJ.J4i 6J£* .

Wietske G. Weigel-Delano, LTC Supervisor

Division of Long Term Care Enclosure

cc: Joani Latimer, State Ombudsman

Bertha Ventura, Dmas ( Sent Electronically )

Ms. Beth Lwin, Administrator November 16, 2017

Page 3

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 1O calendar days of your receipt of the enclosed survey findings.

**An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.**

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency **(DMAS):**

0 Pursuant to §488.408(c)

Directed Plan of Correction (PoC) (§488.424). State monitoring (§488.422).

Directed In-Service Training (§488.425).

0 Pursuant to §488.408( d)

Denial of payment for new admissions - (§488.417). Denial of payment for all individuals - (§488.418).

Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,

* Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

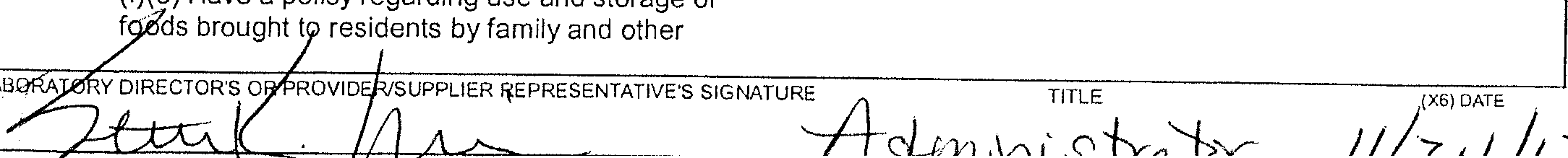
Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

**Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare** & **Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."**

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

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

PRINTED: 11/16/2017 FORM APPROVED 0MB NO. 0938-0391

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **495410** | (X2) MULTIPLE CONSTRUCTION  A BUILDING \_  BWING \_ | | (X3) DATE SURVEY COMPLETED  **11/15/2017** |
| NAME OF PROVIDER OR SUPPLIER  **ARLEIGH BURKE PAVILION** | | | STREET ADDRESS. CITY, STATE, ZIP CODE  **1739 KIRBY ROAD**  **MC LEAN, VA 22101** | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (XS)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY) | | | | |
| F 000 INITIAL COMMENTS F 000  An unannounced Medicare/Medicaid standard survey was conducted 11/13/17 through 11/15/'17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.  The census in this 49 certified bed facility was 44 RECEIVED  at the time of the survey. The survey sample  consisted of 1O current Resident reviews  (Residents# 1 through #10) and three closed  record reviews (Residents# 11 through# 13).  F 371 483.60(i)(1)-(3) FOOD PROCURE, F 371  SS=F STORE/PREPARE/SERVE - SANITARY  (i)(1) - Procure food from sources approved or  considered satisfactory by federal, state or local 12/20/16  authorities.  It is the facility's policy to store and prepare   1. This may include food items obtained directly food in accordance with professional standards from local producers, subject to applicable State   and local laws or regulations. for food service safety.   1. This provision does not prohibit or prevent While both the German chocolate cake and the facilities from using produce grown in facility whipped topping were wrapped they were not gardens, subject to compliance with applicable stored with a use by date. Both items where   safe growing and food-handling practices.  immediately discarded on November 13, 2017.   1. This provision does not preclude residents   from consuming foods not procured by the facility. Upon discovery that there was water in the  Food Processor bowl and the blade was wet. (i)(2) - Store, prepare, distribute and serve food in The Food Processor parts were re-washed and  accordance with professional standards for food  service safety. sanitized and allowed to air dry before  assembly, November 13, 2017. | | | | |

Any deficiency statement ding wit n a erisk (') denotes a deficiency which the institution may be excused from correcting providing it is etermin t at

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **495410** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING \_ 2. WING \_ | | (X3) DATE SURVEY COMPLETED  **11/15/2017** |
| NAME OF PROVIDER OR SUPPLIER  **ARLEIGH BURKE PAVILION** | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **1739 KIRBY ROAD**  **MC LEAN, VA 22101** | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETtmJ  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY) | | | | |
| F 371 Continued From page 1 F 371  visitors to ensure safe and sanitary storage, Upon discovery that there was food debris on  handling, and consumption. the neck of the mixer, other surfaces that would This REQUIREMENT is not met as evidenced  by: come in contact with food items were found to  Based on observation, staff interview and facility be clean, all areas of the mixer were document review, it was determined, the facility immediately properly cleaned and sanitized, staff failed to store and prepare food in a clean  and sanitary manner. November 13, 2017.  The findings include: On November 13, 2017 the meat slicer was dis­ assembled and properly cleaned and sanitized.  Observation and tour of the kitchen was  conducted on 11/13/17 at approximately 6:45 The facilities policy and procedures have been  p.m. with OSM (other staff member)# 6, the reviewed. The following steps will be taken to cook. The following was observed:  ensure compliance related to food storage.  Half of a nine inch, double layer German  chocolate cake, wrapped in plastic was observed • Charts will be displayed for proper  on top of a shelf in the walk-in refrigerator. There storage protocols for specific items for was no label or date indicating when the cake  was opened. When asked when the cake was easy/quick reference for all kitchen  opened and cut, OSM #6 stated she didn't know staff.  and immediately removed the cake from the • The Dining Services staff will receive walk-in refrigerator and disposed of it.  and in-service training regarding  A 16-ounce tube of whipped topping containing storage protocols and the use of the approximately a quarter of whipped topping, reference charts to ensure proper  wrapped in plastic was lying on a shelf in the labeling and dating of all foods stored.  walk-in freezer. There was no label or date  indicating when the whipped topping was opened. • Checklist developed for kitchen  When asked when the whipped topping was personnel to complete daily to ensure opened, OSM #6 stated she didn't know and  immediately removed the whipped topping from compliance and to take corrective  the walk-in freezer and disposed of it. action on the spot.  A food processor was observed on the food The dining services manager will conduct audits preparation table. OSM #6 was asked if the food weekly of all areas to ensure proper labeling  processor was cleaned and ready for use, she and dating all food items. The findings of the stated, "Yes." Further observation of the food | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **495410** | (X2) MULTIPLE CONSTRUCTION  **A.** BUILDING \_  BWING \_ | | (X3) DATE SURVEY COMPLETED  **11/15/2017** |
| NAMF OF PROVIDER OR SUPPLIER  **ARLEIGH BURKE PAVILION** | | | STREET ADORES$, CITY, STATE, ZIP CODE  1739 KIRBY ROAD  **MC LEAN, VA 22101** | |
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| F 371 Continued From page 2 F 371 processor revealed the processing bowl on the  stand with the with the blade attached inside the  bowl and a plastic lid on the bowl. An audits will be documented and reported to the examination of the inside of the bowl revealed a QAPI committee for further monitoring and small pool of water in the bottom of the bowl and  the blade was wet. OSM #6 was asked to process review.  examine the inside of the food processor bowl.  When asked if there was standing water in the The facilities policy and procedures for bottom of the bowl and if the blade was wet, OSM "Cleaning Instructions" have been reviewed. #6 stated, "Yes." When asked if the parts of the The following steps will be taken to ensure  food processor were to be stored wet, OSM #6  stated, "No" and immediately had them removed compliance. to be washed.   * The facilities policy will updated to   A mixer was observed on the food preparation include cleaning and sanitizing  table. OSM #6 was asked if the mixer was equipment both *after* and *before* each cleaned and ready for use, she stated, "Yes."  Further observation of the mixer revealed food use. This was added to assure the  debris on the neck of the mixer. OSM #6 was cleanliness of each piece of equipment  asked to examine the neck of the mixer. When before use especially if the item had not asked if the part was clean, OSM #6 stated, "No."  When asked if the neck of the mixer should have been used for an extended period of been cleaned, OSM #3 stated, "Yes" and time.  immediately instructed another staff member to • The Dining Services staff will receive  wash the mixer.  and in-service training regarding the  A meat slicer was observed on the food change in policy and to assure the  preparation table covered with a plastic bag. proper cleaning and drying of all OSM #6 was asked if the meat slicer was  cleaned and ready for use, she slated, "Yes," equipment.  OSM #6 was then asked to uncover the meat • Checklist developed for kitchen  slicer. Further observation of the meat slicer personnel to complete daily to ensure revealed dried food debris on the housing behind  and beneath the blade. OSM #6 was asked to compliance and to take corrective  examine the housing behind and beneath the action on the spot. blade. When asked if the meat slicer was clean,  OSM #6 stated, "No" and immediately instructed kitchen staff to take the meat slicer apart and wash it. | | | | |

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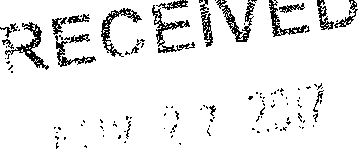
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **495410** | (X2) MULTIPLE CONSTRUCTION  **A** BUILDING  8 WING | | | (X3) DATE SURVEY COMPLETED  **11/15/2017** |
| NAME OF PROVIDER OR SUPPLIER  **ARLEIGH BURKE PAVILION** | | | STREET ADDRESS, CITY. STATE, ZIP CODE  **1739 KIRBY ROAD**  **MC LEAN, VA 22101** | | |
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| F 371 Continued From page 3  On 11/14/17 at approximately 9:00 a.m. an interview was conducted with OSM # 2, dietary manager regarding the findings of the kitchen tour on 11/13/17 with OSM # 6. OSM # 6 stated the cake and the whipped topping should have been dated when opened; the food processor should have been stored dry and the mixer and meat slicer should have been cleaned.  The facility's policy "Cleaning Instructions: Food Preparation Appliances" documented in part, "Policy: Small appliances (such as food processors) will be cleaned and sanitized after each use. Procedure: 5. Air Dry."  The facility's policy "Cleaning Instructions: Slicers" documented in part, "The slicer will be cleaned and sanitized after each use."  The facility's policy "Food Storage" documented in part, "13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded."  Food Code 2009 Recommendations of the United States Public Health Service Food and Drug Administration.  4-601.11 Equipment Food-Contact Surfaces,  Nonfood-Contact Surfaces and Utensils.   1. Equipment food-contact surfaces,   nonfood-contact surfaces and utensils shall be clean to sight and touch.   1. The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. | | F 371 | | The dining services manager will conduct audits weekly of all areas to ensure the equipment is being cleaned and sanitized and dried according to policy. The findings of the audits will be documented and reported to Monthly to the QAPI committee for review and further action. | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **495410** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING \_ 2. WING \_ | | (X3) DATE SURVEY COMPLETED  **11/15/2017** |
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| F 371 Continued From page 4 F 371 On 11/14/17 at approximately 5:30 p.m. ASM  (administrative staff member) #1, the administrator and ASM #2, director of nursing were made aware of the findings.  No further information was obtained prior to exit.  F 387 483.30(c)(1 )(2) FREQUENCY & TIMELINESS OF F 387  SS=D PHYSICIAN VISIT   1. Frequency of Physician Visits    1. The residents must be seen by a physician at 12/15/17   least once *every* 30 days for the first 90 days after  admission, and at least once every 60 thereafter. It is the facility's policy to have our residents  seen by physicians at least once every 30 days   * 1. A physician visit is considered timely if it for the first 90 days after admission, and at least occurs not later than 10 days after the date the   visit was required. once *every* 60 days thereafter.  This REQUIREMENT is not met as evidenced  by: Resident #1 was seen by her attending  Based on staff interview, clinical record review physician 7//31/17 and then by the Medical and facility document review, it was determined, Director on 9/29/17. After repeated attempts  the facility staff failed to ensure timely physician  visits for two of 13 residents in the survey sample, by the facility to have her physician visit within  Residents # 1 and # 5. the 60 day timeline as required, the facilities  Medical Director was asked to see the resident.   1. The facility staff failed to ensure that Resident   # 1 was seen by a physician from 3/23/17 to Resident #5 was seen by her attending 7/31/17, a total of 129 days.  physician 7/27, 8/5, 8/24, 9/21, 10/5,10/19,   1. The facility staff failed to ensure physician visits 10/26 and 11/14.   were conducted every 60 days for Resident #5.  The clinical record documented the physician A facility wide audit of all physician visits has visited Resident #5 on 03/30/17 then not again till been conducted with no additional infractions.  07/27/17, (119 days between visits).  The findings include: | | | | |

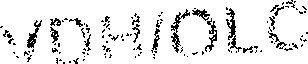
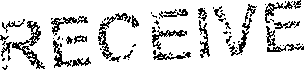


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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **495410** | (X2) MULTIPLE CONSTRUCTION  **A,** BUILDING \_  B. WING ---------- | | (X3) DATE SURVEY COMPLETED  **11/15/2017** |
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| F 387 Continued From page 5 F 387   1. The facility staff failed to ensure that Resident   # 1 was seen by a physician from 3/23/17 to The facilities policy and procedure has been  7/31/17, a total of 129 days,  reviewed with the Medical Director. The  Resident# 1 was admitted to the facility on 8/9/12 following steps have been taken to ensure and most recently admitted on 3/10/14, with compliance:  diagnoses that included, but were not limited to:  congestive heart failure, diabetes, • Medical Records Personnel will monitor gastroesophageal reflux disease, hyperlipidemia,  and arthritis. and track MD visit schedule.   * + Medical Records Personnel to provide Resident# 1's most recent MOS (minimum data status of Physician Visits due monthly set) an annual assessment with an ARD   (assessment reference date) of 10/27/17 to the Administrator and DON.  assessed Resident# 1 as usually understood by • The Medical Director will be notified of others and usually able to understand others. all Physician Visits out of compliance at Resident# 1 was coded as scoring a 10 out of a  possible 15 on the Brief Interview for Mental the 30 day point for his intervention.  Status in Section C, Cognitive Patterns, indicating o Call and confirm physician visits the resident was moderately cognitively impaired, o See residents to prevent past  A review of Resident #1's clinical record revealed due visits. progress notes that were dated 3/23/17 and  7/31/17, a total of 129 days between notes. No All Physician visits will be monitored as a part of other physician notes were provided. our QAPI program and any noncompliance of  During an interview on 11/14/17 at 5:35 p.m. with physician visits will be reported and monitored ASM (Administrative Staff Member)# 1, the to ensure corrective action was taken.  Administrator, ASM # 2, the Director of Nurses, and OSM (Other Staff Member)# 3, the Social Worker, this concern was revealed and a request was made for any other physician notes that could be found between 3/23/17 and 7/31/17.  During an interview on 11/15/17 at 8:50 a.m. with ASM # 1, ASM # 1 stated staff had been having difficulty getting (name of Resident# 1's) physician to come in to the facility to see her. At | | | | |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **495410** | (X2) MULTIPLE CONSTf<UCTION  A. BUILDING \_  BWING | | | | | | | (X3) DATE SURVEY COMPLETED  **11/15/2017** | |
| NAME OF PROVIDER OR SUPPLIER  **ARLEIGH BURKE PAVILION** | | | STREET ADD  **1739 KIRBY**  **MC LEAN,** | | RESS, CITY,  **ROAD**  **VA 22101** | STATE, | ZIP | CODE | | |
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| F 387 Continued From page 6  this time a time line of attempts made to have the physician come in to see the Resident #1 was presented. ASM # 1 was asked which staff member was responsible for keeping track of physician visits. ASM #1 stated (name of OSM # 7), the medical records staff member was responsible. A request was made to interview this staff member.  During an interview on 11/15/17 at 10:16 a.m. with OSM # 7 (ASM # 1 was present during this interview and ASM # 2 walked into the room while the interview was in progress), OSM # 7 was asked what process is followed to keep track of physician visits. OSM # 7 stated she must make sure that the physician comes in on time - every 60 days. OSM # 7 stated there is a binder for each physician that has the due dates that each resident is to be seen. OSM # 7 stated, "I check each binder to see if the physician has seen those residents that are due and if the residents have not been seen I call the physician to remind them. If after another week the residents have not been seen I make a report to the Administrator and the Director of Nurses. I also make notes in the computer of the dates and times I have called the physician." OSM # 7  identified the notes presented by ASM # 1 as her  (OSM # Ts) notes.  During an interview on 11/15/17 at 12:07 p.m. with ASM # 1 and ASM # 2, this concern was again reviewed.  Review of the facility policy: "PHYSICIAN SERVICES and MEDICAL SUPERVISION OF  RESIDENTS...# 6. Each resident's total program of care shall be reviewed and revised at intervals appropriate to his needs. Residents must be | | F 387 | | | | | | | | |



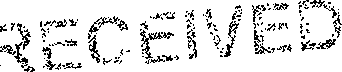


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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **495410** | (X2) MULTIPLE CONSTRUCTION  A BUILDING  B. WING | | | | | | | (X3) DATE SURVEY COMPLETED  **11/15/2017** | |
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| F 387 Continued From page 7  seen by a physician at least once every thirty (30) days for the first ninety (90) days after admission and at least every sixty (60) days thereafter..."  No further information was provided prior to exit.  2. The facility staff failed to ensure physician visits were conducted every 60 days for Resident #5. The clinical record documented the physician visited Resident #5 on 03/30/17 then not again till 07/27/17, (119 days between visits).  Resident #5 was admitted to the facility on 08/13/13 with diagnoses that included but were not limited to: atrial fibrillation (1), heart failure, diabetes mellitus without complication (2), edema (3), and Alzheimer's disease (4).  Resident #S's most recent MOS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/20/17, coded Resident #5 as scoring a two on the brief interview for mental status (BIMS) of a score of O  - 15, two being severely impaired of cognition for making daily decisions. Resident #5 was coded as requiring limited assistance of one staff member for activities of daily living.  A review of the clinical record revealed the physician visited Resident #5 on 03/30/17 then not again till 07/27/17, 119 days between visits.  On 11/15/17 at approximately 9:00 a.m. ASM (administrative staff member) #2, the director of nursing provided this surveyor with a "Progress Note" by Resident #S's physician. The note was signed by the physician but was not dated. The "Progress Note" documented, "Dates of visits reviewed. There was a gap form March 30, 2017 to July 27, 2017. It is highly unlikely that I did not | | F 387 | | | | | | | | |





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| s·1ATEMFN I OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIEHICLIA IDENTIFIC/\TION NUMBER:  **495410** B | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  WING | | | | | | | (X3) DATE SURVEY COMPLETED  **11/15/2017** | |
| NAME or PROVIDER OR SUPPLIER  **ARLEIGH BURKE PAVILION** | | | STREET ADD  **1739 KIRBY**  **MC LEAN,** | | RESS. CITY,  **ROAD**  **VA 22101** | STATE, | ZIP | CODE | | |
| (X•1) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST flE PRECEDED BY FULL  TAG 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 387 Continued From page 8  see (Resident #5) in that interval. She is in the day area often during my Thursday visits and I check her frequently. If it is important to know, I can check the billing personal to see if I submitted an additional visit in the gap."  On 11/15/17 at 10:20 a.m. an interview was conducted with **OSM** (other staff member)# 7, director of medical records. When asked how often a resident needs to be seen by the physician, OSM # 7 stated, "One time per month for the first three months and every sixty days afterwards." When asked how he ensures the physician sees the residents every sixty days, OSM #7 stated, "Each physician has a binder and it has a log of their residents and the due dates for visits/notes. I check the binders on a monthly basis. If a physician is late I call the physician. If a note/visit is not done after a week I notify the administrator and call the physician again and make a note that I've contacted the physician." When asked if she had the note of when  Resident #5's physician was contacted, OSM #7 stated, "No. It was an oversight for (Resident #5's) physician because he is in the facility every Thursday to see (Resident #5) and I didn't check."  On 11/15/17 at approximately 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing were made aware of the findings.  No further information was obtained prior to exit. References:  1. A problem with the speed or rhythm of the heartbeat. This information was obtained from | | F 387 | | | | | | | | |



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICAf E & MEDICAID SERVICES

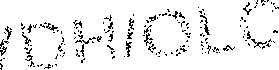
PRINTED: 11/16/2017 FORM APPROVED 0MB NO 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 111811 Facilily ID: VA0407 If continuation sheet Page 10 of 14

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| STATEMEI'1T OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/Cl.IA IDENTIFICATION NUMBER:  **495410** | (X2) MULTIPLE CONSTRUCTION  A. BUILDING \_  B.WING---------- | | (X3) DATE SURVEY COMPLETED  **11/15/2017** |
| NAME OF PROVIDER OR SUPPLIER  **ARLEIGH BURKE PAVILION** | | | STREET ADDRESS. CITY. STATE, ZIP CODE  1739 KIRBY ROAD  **MC LEAN, VA 22101** | |
| (X4) ID SUMMARY STATEMENT OF DEFICIE:NCIES ID PROVIDER'S PLAN OF CORRECTION (XS)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIOI  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY) | | | | |
| F 387 Continued From page 9 F 387 the website:  https:/[/www.nlm.nih.gov/m edlineplus/atrialfibrillati](http://www.nlm.nih.gov/medlineplus/atrialfibrillati)  on.html.   1. A chronic disease in which the body cannot regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm. 2. A swelling caused by fiuid in your body's tissues. This information was obtained from the website:   [https://www.nlm.nih.gov/medlineplus/edema.html.](http://www.nlm.nih.gov/medlineplus/edema.html)   1. A brain disorder that seriously affects a person's ability to carry out daily activities) This information was obtained from the website: [https://www.nlm.nih.gov/medlineplus/alzheimersdi](http://www.nlm.nih.gov/medlineplus/alzheimersdi) sease.html.   F 441 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, F 441  SS=E PREVENT SPREAD, LINENS  (a) Infection prevention and control program.  12/15/17  The facility must establish an infection prevention  and control program (!PCP) that must include, at It is the facility's policy to maintain an infection  a minimum, the following elements: prevention and control program in order to  (1) A system for preventing, identifying, reporting, provide a safe, sanitary environment to help investigating, and controlling infections and prevent development and transmission of  communicable diseases for all residents, staff, communicable diseases and infections. volunteers, visitors, and other individuals  providing services under a contractual | | | | |



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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **495410** | (X2) MULTIPLE CONSTRUCTION  A !3UILDING  B. WING ------- ·-- ---·--·-· --- ·-··· | | (X3) DATE SURVEY COMPLETED  **11/15/2017** |
| NAME OF PROVIDER OR SUPPLIER  ARLEIGH BURKE PAVILION | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **1739 KIRBY ROAD**  **MC LEAN, VA 22101** | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE.  DEFICIE ICY) | | | | |
| F 441 Continued From page 10 F 441 arrangement based upon the facility assessment  conducted according to §483.70(e) and following On November 15, 2017 the fan was cleaned accepted national standards (facility assessment then removed from clean linen room and ceiling implementation is Phase 2);  vent and surrounding tiles cleared of all dust   1. Written standards, policies, and procedures and lint. for the program, which must include, but are not   limited to: A cover has been ordered for clean linen cart on   * 1. A system of surveillance designed to identify November 22, 2017. The cover will provide possible communicable diseases or infections protection to the clean linen.   before they can spread to other persons in the  facility; A facility wide tour was conducted with no  additional infractions.   * 1. When and to whom possible incidents of   communicable disease or infections should be The facility's policy and procedures and reported;  practices for cleaning the Laundry Area were   * 1. Standard and transmission-based precautions reviewed. The following changes have been to be followed to prevent spread of infections; made:   2. When and how isolation should be used for a • Laundry personnel will clean using a resident; including but not limited to:   checklist daily   * + 1. The type and duration of the isolation, • Manager will complete a quality control depending upon the infectious agent or organism checklist weekly to ensure compliance.   involved, and   * + 1. A requirement that the isolation should be the The daily checklist and quality control checklist least restrictive possible for the resident under the   circumstances. will be reviewed monthly for compliance and effectiveness. The Housekeeping/Laundry   1. The circumstances under which the facility manager will report Monthly to the QAPI   must prohibit employees with a communicable  disease or infected skin lesions from direct committee the effectiveness of the Checklists  contact with residents or their food, if direct and the committee will take further action, if contact will transmit the disease; and needed.   1. The hand hygiene procedures to be followed | | | | |



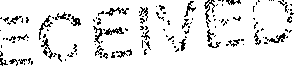


DEPARTMENT OF HEAL**TH** AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION f UMBER  495410 | (X2) MULTIPLE CONSTRUCTION  A BUILDING \_  B. WING | | | | | | | (X3) DATE SURVEY COMPLETED  **11/15/2017** | |
| NAME OF PROVIDER OR SUPPLIER  **ARLEJGH BURKE PAVILION** | | | STREET ADD  **1739 KIRBY**  **MC LEAN,** | | RESS, CITY,  **ROAD**  **VA 22101** | STATE, | ZIP | CODE | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | | | (XS) COMPLETION DATE |
| F 441 Continued From page 11  by staff involved in direct resident contact.  (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.   1. Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. 2. Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.   This REQUIREMENT is not met as evidenced  by:  Based on observation and staff interview, it was determined, the facility staff failed to process and store linens in a sanitary manner.  The facility staff failed to keep air vent and fans free of dust when folding and storing clean linens.  The findings include:  On 11/15/17 at **11**:30 a.m. an observation of the facility's laundry room was conducted with OSM (other staff member) #8 maintenance manager, OSM #9, director of facility and environmental services, OSM #10, housekeeping account manager, and OSM **#11,** laundry staff.  The laundry room consisted of a dirty linen room that contained a commercial clothes washer and soiled linens and soiled resident clothing.  Another separate room adjacent to the soiled linen room was the clean laundry area. The area contained two commercial clothes dryers, table for folding clean linens and clothing. The area also contained a clean laundry rack measuring 60 | | F 441 | | | | | | | | |



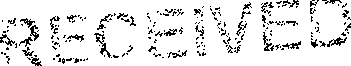


DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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| S !Al EMENT OF DEFICIENCIES At,O PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **495410** | (X2) MULTIPLE CONSTRUCTION  A BUILDING \_  8W.ING | | | | | | | (X3) DATE SURVEY COMPLETED  **11/15/2017** | |
| NAME or PROVIOEn OR SUPPLIER  **ARLEIGH BURKE PAVILION** | | | STREET ADD  **1739 KIRBY**  **MC LEAN,** | | RESS, CITY,  **ROAD**  **VA 22101** | STATE, | ZIP | CODE | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | | | (XS) COMPLETION DATE |
| F 441 Continued From page 12  inches wide by 24 inches deep and 58 inches high with four shelves and a clean laundry cart filled with clean bed pads to be folded. Further observation of the table for folding clean linen revealed 34 clean and folded washcloths and a clean and folded bath blanket. The laundry cart with the clean bed pads was in front of the clean folding table uncovered. The clean laundry rack contained numerous clean and folded towels, bed  sheets and resident clothing and was observed to  be uncovered.  Further observation of the clean laundry area revealed a table top fan sitting on top of a refrigerator across from the clan folding table and the clean laundry cart. The fan was blowing toward the clean folding table and over the top of the clean laundry cart. OSM #11 was asked to turn the fan off. Observation of the fan revealed the fan blades and the front and rear finger guards were covered with grey dust/lint.  Observation of the ceiling above the clean folding table and clean laundry cart revealed a 24 by  24-inch ceiling vent with diffuse baffles blowing air in four directions of the clean laundry area.  Further observation of the ceiling vent revealed the diffuse baffles were coated with grey colored dust and the surrounding ceiling tiles around the vent were observed with pieces of dust and lint hanging from them.  When asked about the process of cleaning the fans and air vents OSM #11 stated they are cleaned every Friday. OSM # 1 was asked to turn *off* the table top fan that was blowing in the clean linen folding room. When asked if the fan was clean, OSM #11 stated no and agreed the fan blades and finger guards were covered in dust/lint. When asked if the clean washcloths | | F 441 | | | | | | | | |



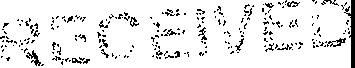
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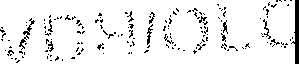
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

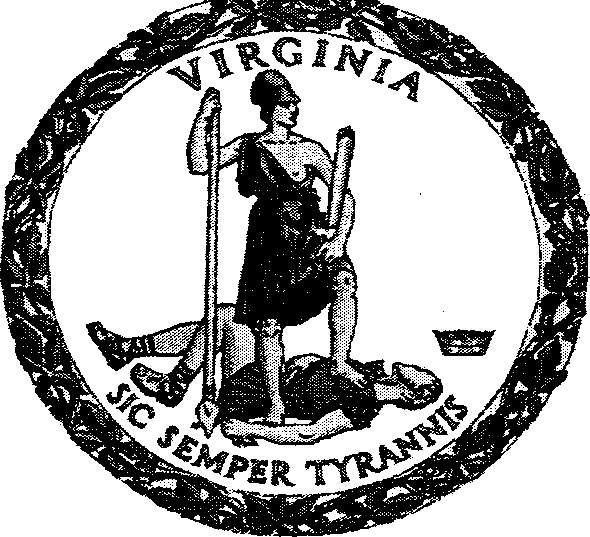
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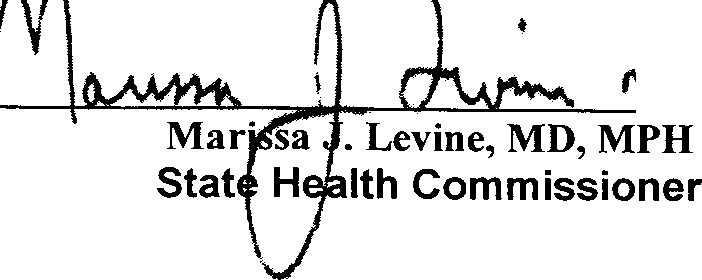
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:ll1G11 Facility ID: VA0407 If continuation sheet Page 14 of 14

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| STATEMENT OF DEFICIENCIES AND PL/IN OF CORRECTION | {X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:  **495410** | {X2) MULTIPLE CONSTRUCTION  A BUILDING \_  B. WING \_ | | | | | | (X3) DATE SURVEY COMPLETED  **11/15/2017** | |
| NAME OF PROVIDER OR SUPPLIER  **ARLEIGH BURKE PAVILION** | | | STREET ADD  **1739 KIRBY**  **MC LEAN,** | | RESS, CITY,  **ROAD**  **VA 22101** | STATE. | ZIP CODE | | |
| (X4)ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX {EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | | (XS) COMPLETIOCJ DATE |
| F 441 Continued From page 13  and laundry cart with the clean bed pads should have been set and folded in front of the dirty table top fan, OSM #11 stated, "No." OSM #9, OSM #10 and OSM #11 were then asked to observe the ceiling air vents and the clothes racks in the room. Upon observing the vent OSM #10 and OSM #11 agreed the vent and surrounding ceiling tiles were coated with dust/lint. They further agreed the clean laundry rack was exposed to the air being blown from the ceiling vent. OSM #11 further stated she did not notice how dirty the fan or ceiling vent was. OSM #11 stated all the clean clothing and linen on the folding table, laundry cart and laundry rack would be removed immediately and rewashed.  OSM #10, housekeeping account manager, stated the fan and vent would be cleaned immediately and a plan would be put in place to address the cleaning of the fan and vent.  On 11/15/17 at approximately 12:10 p.m. ASM (administrative staff member) #1, the administrator, and **ASM #2,** director of nursing, were made aware of the findings.  No further information was obtained prior to exit. | | F 441 | | | | | | | |









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**Commonwealth of Virginia Virginia Department of Health**

Nursing Home License Number: **NH2480**

*In accordance with the provisions of Title 32.1. Chapter 5, Article 1, of the Code of Virginia 1950, as amended.*

**Vinson Hall, LLC**

(Operator)

**is Authorized to Operate,**

**Arleigh Burke Pavilion**

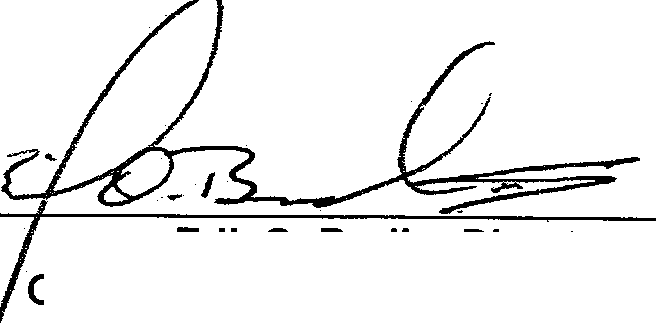
(Name of Organization)

**a Nursing Home, located at:**

**1739 Kirby Road, McLean, Virginia 22101**

Approved Capacity **49** Beds Expiration 12/31/2018

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Erik 0. Bodin, Director Office of Licensure and Certification

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Nursing Home Application

**Virginia Department of Health Application for Nursing Home License**

In accordance with the provisions of Chapter 5, Article 1, Title 32.1, Code of Virginia of 1950, all non-federal medical and nursing facilities desiring license as a nursing home in Virginia must submit the following information to the Virginia Department of Health.

Any changes during the year. which would affect the accuracy of the following information, must be reported promptly, In writing, to the Virginia Department of Health.

Application for: (check one)

Annual Renewal for Calendar Year

D Initial License to Operate a Nursing Home

D Changes in Licensed Bed Capacity/Bed Change

D Changes in Ownership or Operator

Effective Date: 01/01/2018

**Name of Facility (Doing Business As name):** Arleigh Burke Pavilion

**Facility Physical Address:** 1739 Kirby Road

**(Additional space if needed)**

**City Or Town:** Mclean

**County:** Fairfax,

**Telephone Number with Area Code:** 703-506-6900

**State:** VA **Zip Code:** 22101

**Fax Number:** 703-506-6988

**Mailing Address:** Same as above **Facility E-Mail Address:** [bethl@vinsonhall.org](mailto:bethl@vinsonhall.org) **Facility Web Address:** [www.vinsonhall.org](http://www.vinsonhall.org/)

**Name of Administrator of Record:** Beth K. Lwin

**If the facility is Medicare/Medicaid certified, has the facility registered for ePOC? YES** [2:1 **NOD NOT Certified** D

**If "YES," enter date registered and name of ePOC user.** 10/02/2017 Beth K. Lwin

I **hereby certify that the above named facility is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1 Cha Article 2 Ri ht and Res onsibilities of Patients in Nursin Homes.**

1701002733



(Nursing Home Administrator's License Number)

**Conditioned Certificate of Public Need for Indigent and Specialty Care:** I **hereby certify that the facility named on this application is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article 1, Section 32.1-102.C. The facility has reviewed its status regarding Certificates of Public Need issued to it, and has determined that:**

1. Conditioned certificates for indigent or specialized care are applicable to the nursing facility. **DYES NO**
2. If conditioned certificates for indigent or specialized care are applicable to this nursing facility, does the nursing facility meet the requirements of the certificates? 0 **YES** D **NO** (If "NO," attach a letter of explanation)

I hereby certify that the information contained in the Application for License Renewal is, to the best of my knowledge, accurate and

*true.\_>--//?* / \_/ '

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(Signature of Administrator/Chief Officer) Completed)

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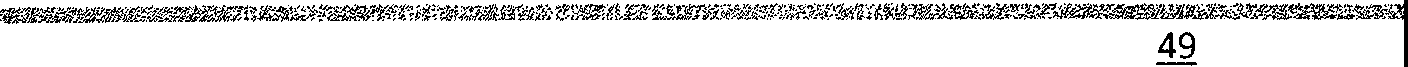
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Nursing Home Application

**Licensing Classification of Nursing Home Facilities and Bed Capacity by Service**

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Types of Beds by License Classification Bed Capacity



Licensed Beds Requested

Total Bed Capacity (Specify Bed Types excluding Day Care)

Number of Beds Certified for Medicare Only (Title 18)

Number of Beds Certified for Medicare/Medicaid (Title 18/19)

Number of Beds Certified for Medicaid only (Title 19)

Number of Non-certified beds (Exclude Adult Residential beds)

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**Does the facility have a specialized unit?** YES [8J **NO**

**If yes, specify the type of specialized unit and number of beds (i.e. secured unit, ventilator unit, etc.)?**

**Type of Unit Number of beds**

□

Does the facility have a Nurse Aide training program on your premises?

If yes, is it a certified Nursing Assistant Program approved by the Board of Nursing?

|  |  |  |
| --- | --- | --- |
| **A.** | **Name of Director of Nursing Service:** Hawa Lamin-Sidiquie, RN, MSN | **Start Date:** 05/12/14 |
| **B.** | **Name of In-Service Training Director:** Joanne Burke, RN-BC | **Start Date:** 04/27/OS |
| **C.** | **Name of Social Services Director:** Terrell Timms | **Start Date:** 01/07/16 |
| **D.** | **Name of Activities Director:** Jocelyn Jackson | **Start Date:** 05/04/16 |
| **E.** | **Name of Food Services Supervisor:** Lemont Jolley | **Start Date:** 04/20/16 |
| **F.** | **Name of Medical Director/Advisory Physician(s):** Dr. Nadeem Qazi | **Start Date:** 08/07/17 |
| **G.** | **Name of Dietary Consultant:** Debra Fischer | **Start Date:** 12/03/11 |
| **H.** | **Name of Pharmacy Consultant:** Omnicare | **Start Date:** 04/01/11 |
| I. | **Name of Physical Therapy Consultant:** Select Rehab | **Start Date:** 02/29/16 |
| **J.** | **Name of Dental Consultant:** Dr. Mantoni | **Start Date:** 07/14/15 |



□**YES**

**YES**

[8J **NO**

NO

□

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**Survey of Long-Term Care Facilities**

Nursing Home Application

Facility Name (Doing Business As name): Arleigh Burke Pavilion

(Please make sure the Facility Name is spelled the same as on page 5)

Is any part of the facility licensed by another state agency? YES NO D If yes, enter the number of beds: 32 If yes, specify the type of beds (i.e. Adult Residential) Assisted Living

Does the facility have Adult Day Care facilities? YES D NO If yes, enter the number of accommodations: Does the facility have Child Day Care facilities? YES D NO If yes, enter the number of accommodations: If yes, are the day care facilities required to be licensed by the Department of Social Services? DYES D NO



Does the facility share resources with an Assisted Living Facility? YES NOD Ifyes, complete the following section: Assisted Living Facility Name: Arleigh Burke Pavilion

Number Of Assisted Living Facility Beds: 32

State licensure laws and regulation do not prohibit the integration or sharing of services/areas within nursing facility/assisted living arrangements. However, providers must demonstrate compliance with all relevant licensure regulations regarding full time staffing and facility environmental requirements. Providers are obligated to assure that staffing assignments and shared services are sufficient to meet the assessed needs of all residents and the applicable regulations for each type of facility license. Please complete the questions below addressing sharing of staff, services, and areas.

* 1. Are residents of the two facilities in:

0 Same wing O Different wing,

Same building, 0 Separate buildings, same campus, Other: Upper level is nursing home. lower level is assisted Living

* 1. What services/areas are commonly shared?

0 Direct care, Administrative, Housekeeping,

Other: Maintenance

Foodservice/dietary,

* 1. What staff positions are shared and what is the frequency of duties shared?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Duties | No. of Staff | No. of  Shared Staff | Frequency Daily or Weekly | Duties | No. of Staff | No. of  Shared Staff | Frequency Daily or Weekly |
| Direct Care Staff | 0 | 0 | 0 | Housekeeping | 7 | 7 | daily |
| Administrative Staff | 5 | 5 | daily | Food/service Dietary | 10 | 10 | daily |
| Other: | | | | | | | |

* 1. How are the Administrator duties conducted? Separate for each facility? [gl YES D NO. If no, there must be an Assistant Administrator. Describe how the duties are delegated and how the Administrator is kept informed.

Enter duties delegated

The nursing unti and assisted living unit have their own dedicated staff. the NHA provides financial, business and contract

oversight and directs support services through department managers for the entire building. Mornisng meeting are help with clinical staff and the Administrator for proper support when needed.

Enter how Administrator is informed f fECEIV .,

Morning meetings are help with clinical and non- clinical department managers with the Administrator for proper support

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when needed.

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Is the facility part of a CCRC? YES NOD Ifyes, complete the following section:

1. How many beds are in the CCRC? 492
2. How many Life Care Contract holders are in NON nursing home beds? ON/A not a life care community

7 of 15

09/08/2016

Ownership and Operation of Nursing Home

Nursing Home Applicat;on

Facility Name (Doing Business As name): Jk!gh Burke Pavilion (Please make sure the Facility Name is spelled the same as on page 5)

Legal name of the Operator of the facility: YJnson Hall, LLC

Operator's physical address: 1739 Kirby Road (Additional space if needed) \_

City or Town: fv1cLean State: VA,

Operator Telephone Number with Area Code: 703-506-6900

Zip Code: 221\_Q1

Fax with area fJ)\_g 703-506-6988

Legal/Doing Business As name of the Owner of the nursing home business: Vinson Hall, LLC Owner's physical address: 1739 Kirby Road

(Additional space if needed)

City or Town: McLean  Zip Code: 2210:],

Is the facility operated by the owner of the building? Is the facility owned by the owner of the building?

[ZJYES [ZJ YES

QNO

[]NO

Type of Ownership and Control

If the facility owner-operated, select ONE from Column A.

If the facility IS NOT operated by the owner, select ONE from Column A and ONE from Column B.

(A) (B)

OWNER OPERATOR

(of facility) (of facility)

State or Local Government:

State County City(ies)

□ □

□ □

Mu ltijurisdictional

* □ Hospital District/Authority

Non-Profit:

* □ Church Related

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□

□

Non-Profit Corporation Other Non-Profit

Proprietary:

Single Proprietary Partnership Corporation

□ □

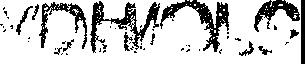
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Limited Liability Corporation

Is there any person other than those listed on this form (owner, operator, administrator of record) who is authorized to make administrative management decisions regarding the facility? r2] YES D NO

If yes, please identify the person and their relationship to the facility

Person's name and relationship to facility Michael Hendee. Chief Operationg Officer ,,·d:.:CEIVi=::



9 of 15 09;08/2016

**Information Required on the Operator/Manager of the Facility**

Nursing Home Application

Please enter the names and Physical addresses of the governing body. If the position is vacant, please put "vacant." If more space Is needed, please attach additional pages to the back of the application

Name of President/Chair: VADM W. Mark Skinner, USN(Ret)

Physical Address: 6251 Old Dominion Drive, McLean, VA 22101

Name of Vice President: RADM Robert 0. Wray, USN(Ret)

Physical Address: 6251 Old Dominion Drive, McLean, VA 22101

Name of Secretary: RADM William R. Rowley, MC, USN(Ret) Physical Address: 6251 Old Dominion Drive, McLean, VA 22101

Name of Treasurer: CAPT W. Scott Slocum, USN(Ret)

Physical Address: 6251 Old Dominion Drive, McLean, VA 22101

If any officer, director, trustee or any member of the governing body or any other individual, partnership, association, trust, corporation, or other legal or commercial entity owns, holds or has a financial interest of five (5) percent of more in the operating/management entity, list the name and percentages of ownership below:

OWNERSHIP PERCENTAGE

Are al! remaining financial interests less than 5 percent?

If the operator/manager has a lease or management agreement with the legal entity or individual who owns the physical plant/buildings, list the name and the address of the building owner.

Name of Building Owner: N/A Physical Address of Owner:

If the operator/manager has a lease or management agreement with a legal entity or individual who is not the owner of the physical plant/buildings, list the name and address of the lessor.

Name of Lessor: *!i/P;*

Physical Address of Lessor:

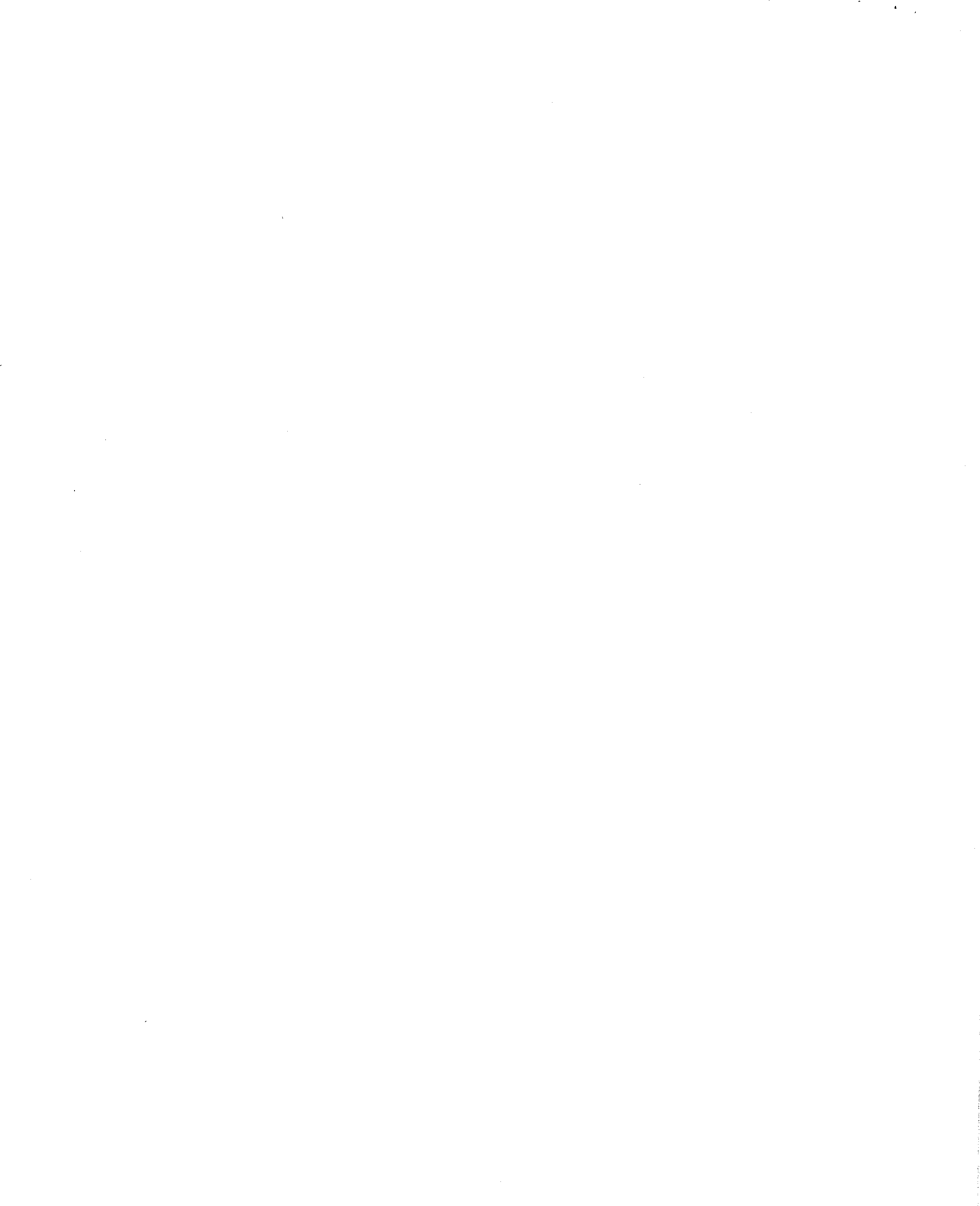
If the operator/manager has a lease or management agreement with an owner or a lesser, does the owner or the lessor have a five (5) percent or more ownership interest in the legal entity that operates/manages the facility? DYES D NO

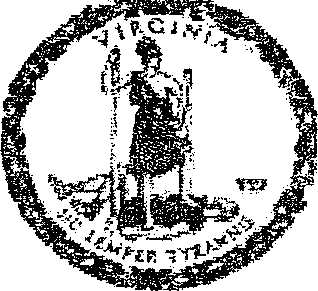
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 10 of 15 09i08i2016





Marissa J. Levine, MD, MPH, FAAFP State Health Commissioner

***COMJlJO IWEALTH of VIRGINIA***

*Department of Health*

Office of Licensure and Certification **1-800-828-1120**

**TYY 7-1-1 OR**

9960 Mayland Drive, Suite 401

Henrico, Virginia 23233-1485

Fax(804)527-4502

January 8, 2018

Ms. Beth Lwin, Administrator Arleigh Burke Pavilion

1739 Kirby Road

Mc Lean, VA 22101

RE: Arleigh Burke Pavilion Provider Number 495410

Dear Ms. Lwin:

Based on deficiencies cited during the survey ending November 15, 2017, your facility was found not to be in substantial compliance with the Federal participation requirements for the long term care Medicare/Medicaid program. The deficiencies cited during the most recent onsite survey did not result in a Scope and Severity grid placement of "G" through "L" or a finding of Substandard Quality of Care (grid placements of "F" and "H" through "L").

By copy of this letter, we are notifying the Centers for Medicare and Medicaid Services (CMS) and/or the state Medicaid agency (Virginia Department of Medical Assistance Services DMAS) that based on our acceptance of the previously received Plan of Correction (PoC), your Allegation of Compliance (AoC) of December 20, 2017, we will presume substantial compliance with CFR Part 483, Subpart B, at this time. **Please be advised that compliance with the above listed Health requirements does not necessarily end the Federal enforcement track. You must also achieve compliance with the Life Safety Code in order to end any enforcement action that may be in effect.** Failure to maintain substantial compliance may result in denial of Medicare and/or Medicaid payments for new admissions, the imposition of other Federal or State remedies, or termination of the provider agreement.

If you have any questions concerning the content of this letter, please contact me at (804) 367-2100. Sincerely,

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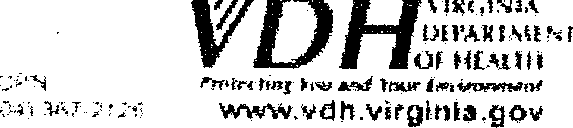
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Wietske G. Weigel-Delano, LTC Supervisor Division of Long Term Care Services

cc: Bertha Ventura, DMAS ( Sent Electronically )

Joani Latimer, State Ombudsman (Sent Electronically)

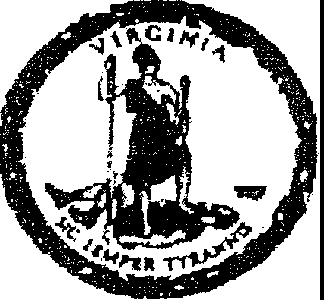
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*COMMONWEALTH of VIRGINIA*

*Department o\_f'Health*

Marissa J. Levine, MD, MPH, FAAFP State Health Commissioner

Office of Licensure and Certification TYY 7-1-1 OR

9960 Mayland Drive, Suite 401

1-800-828-1120

Henrico, Virginia 23233-1485

Fax (804) 527-4502

December 22, 2016

Ms. Kathryn Branch, Arleigh Burke Pavilion 1739 Kirby Road

Mc Lean, VA 22101

RE: Arleigh Burke Pavilion Provider Number 495410

Dear Ms. Branch:

Based on deficiencies cited during the survey ending November 16, 2016, your facility was found not to be in substantial compliance with the Federal participation requirements for the long term care Medicare/Medicaid program. The deficiencies cited during the most recent onsite survey did not result in a Scope and Severity grid placement of "G" through "L" or a finding of Substandard Quality of Care (grid placements of "F" and "H" through 11LII).

By copy of this letter, we are notifying the Centers for Medicare and Medicaid Services (CMS) and/or the state Medicaid agency (Virginia Department of Medical Assistance Services DMAS) that based on our acceptance of the previously received Plan of Correction (PoC), your Allegation of Compliance (AoC) of December 20, 2016, we will presume substantial compliance with CFR Part 483, Subpart B, at this time. **Please be advised that compliance with the above listed Health requirements does not necessarily end the Federal enforcement track. You must also achieve compliance with the Life Safety Code in order to end any enforcement action that may be in effect.** Failure to maintain substantial compliance may result in denial of Medicare and/or Medicaid payments for new admissions, the imposition of other Federal or State remedies, or termination of the provider agreement.

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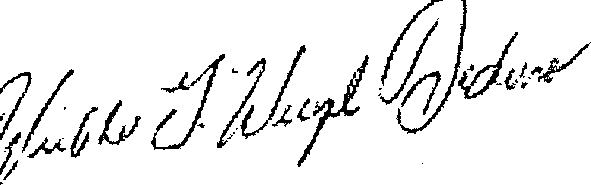
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Ms. Kathryn Branch, December 22, 2016

Page 2

If you have any questions concerning the content of this letter, please contact me at (804) 367-2100. Sincerely,

Wietske G Weigel-Delano, LTC Supervisor Division of Long Term Care Services

cc: Jamie Desper, DMAS (Sent Electronically)

Joani Latimer, State Ombudsman (Sent Electronically)



*COMMONWEALTH of·VIRGINIA*

Marissa J. Levine, MD, MPH, FAAFP State Health Commissioner

*Department o/Health*

Office of Licensure and Certification TYY 7-1-1 OR

1-800-828-1120

9960 Mayland Drive, Suite 401

Henrico, Virginia 23233-1485

Fax(804)527-4502

November 17, 2016

Ms. Kathryn Branch, Administrator Arleigh Burke Pavilion

1739 Kirby Road

Mc Lean, VA 22101

RE: Arleigh Burke Pavilion Provider Number 495410

Dear Ms. Branch:

An unannounced standard survey, ending November 16, 2016, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. No complaints were investigated during the survey.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

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Ms. Kathryn Branch, November 17, 2016

Page 2

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of E), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Wietske G Weigel-Delano, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

* 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
  2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
  3. Address what measures will be put.into place or systemic changes made to ensure that the deficient practice will not recur;
  4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
  5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

**The PoC will serve as the facility's allegation of compliance.** If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

**Following the receipt and review of your survey report,** please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at ["http://www.vdh.state.va.us/OLC/longtermcare/".](http://www.vdh.state.va.us/OLC/longtermcare/)

Ms. Kathryn Branch, November 17, 2016

Page 3

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

**An incomplete informal dispute resolution process w\_ill not delay the effective date of the imposition of any enforcement actions.**

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency **(DMAS):**

* + - Pursuant to §488.408(c)

Directed Plan of Correction (PoC) (§488.424). State monitoring (§488.422).

Directed In-Service Training (§488.425).

* + - Pursuant to §488.408( d)

Denial of payment for new admissions - (§488.417). Denial of payment for all individuals - (§488.418).

Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,

* + - Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

**Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."**

**Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.**

Ms. Kathryn Branch, November 17, 2016

Page 4

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: ["http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20respon](http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20respon) se%20form.pdf". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100. Sincerely,

*MU "*

Wietske G Weigel-Delano, LTC Supervisor Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman

Jaime Desper, D M A S ( Sent Electronically )

DEPARTMENT OF HEALTH AND h .AN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

. **Standard Survey**

From: Fl [][Il [][5] [JJ[}J To: F2 [Il[J] [I][JJ [IJ[Q

MM DD YY MM DD YY

**Extended Survey**

From: F3 □□ □□ □□ To: F4 □□ □□ □□

MM DD YY MM DD YY

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Facility  *!,\y\e; \Ge\_,* IP v,\ OV\ | | | Provider Number  *Lf G[ 51+10* | | | Fiscal Year Endi F5  ct\_1 rn ctr  MM DD YY | | ·--  \ |
| Street Address  \7 Cf k rbl {<\_,6cvl\_ | City  ({¼cl-e- | | | Countyr  Fa..,,,rr5y:. | State  *VA* | | Zip Code  &""\O |
| Telephone Number: F6  1 o **S-** 5\)y- *lp* l *DO* | | State/County Code: F7  pZ9o | | | State/Region Code: F8  0 3ff9 | | | |

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01 Skilled Nursing Facility (SNF) - Medicare Participation 02 Nursing Facility (NF) - Medicaid Participation

03 SNF/NF - Medicare/Medicaid

1. Is this facility hospital based? Fl0 Yes D No [V

If yes, indicate Hospital Provider Number: Fl 1 DDDDDDD

Ownership: F12 **[5**

**For Profit**

01 Individual

**NonProfit**

04 Church Related

07 State

**Government**

10 City/County

* 1. Partnership
  2. Corporation

1. Nonprofit Corporation
2. Other Nonprofit
3. County
4. City
5. Hospital District
6. Federal

Owned or leased by Multi-Facility Organization: F13 Yes D No

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 DOD AIDS Fl6 DOD Alzheimer's Disease

□□□ □□□

Fl7 Dialysis F18 Disabled Children/Young Adults

Fl9 DOD Head Trauma F20 ODD Hospice

F21 DOD Huntington's Disease F22 ODD Ventilator/Respiratory Care F23 DOD Other Specialized Rehabilitation

Does the facility cunently have an organized residents group?

Does the facility currently have an organized group of family members of residents? Does the facility conduct experimental research?

Is the facility part of a continuing care retirement community (CCRC)?

F24 F25 F26 F27

Yes

Yes Yes D Yes Ci}---

No □

No □

NoCV-

□

No

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 DD DD DD Hours waived per week: F29 \_

Waiver of 24 hr licensed nursing requirement. Date: F30 DD DD DD Hours waived per week: F31 \_

MM DD YY

Does the facility currently have an approved Nurse Aide Training

and Competency Evaluation Program? F32 Yes D No Form CMS-671 (12/02)

FACILITY STAFFING

A B C

**D**

Tag

Services Provided

**Full-Time Staff (hours)**

**Part-Time Staff**

**Contract**

Number, \_,

**(hours)**

**(hours)**

Administration F33

Physician Services F34

Medical Director F35

Other Physician F36

Physician Extender F37

**Nursing Services** F38

RN Director of Nurses F39

Nurses with Admin. Duties F40

Registered Nurses F41

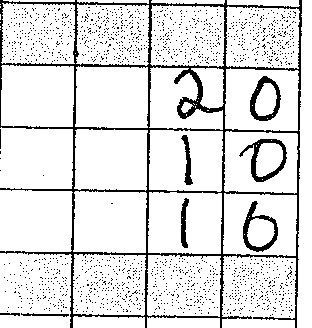
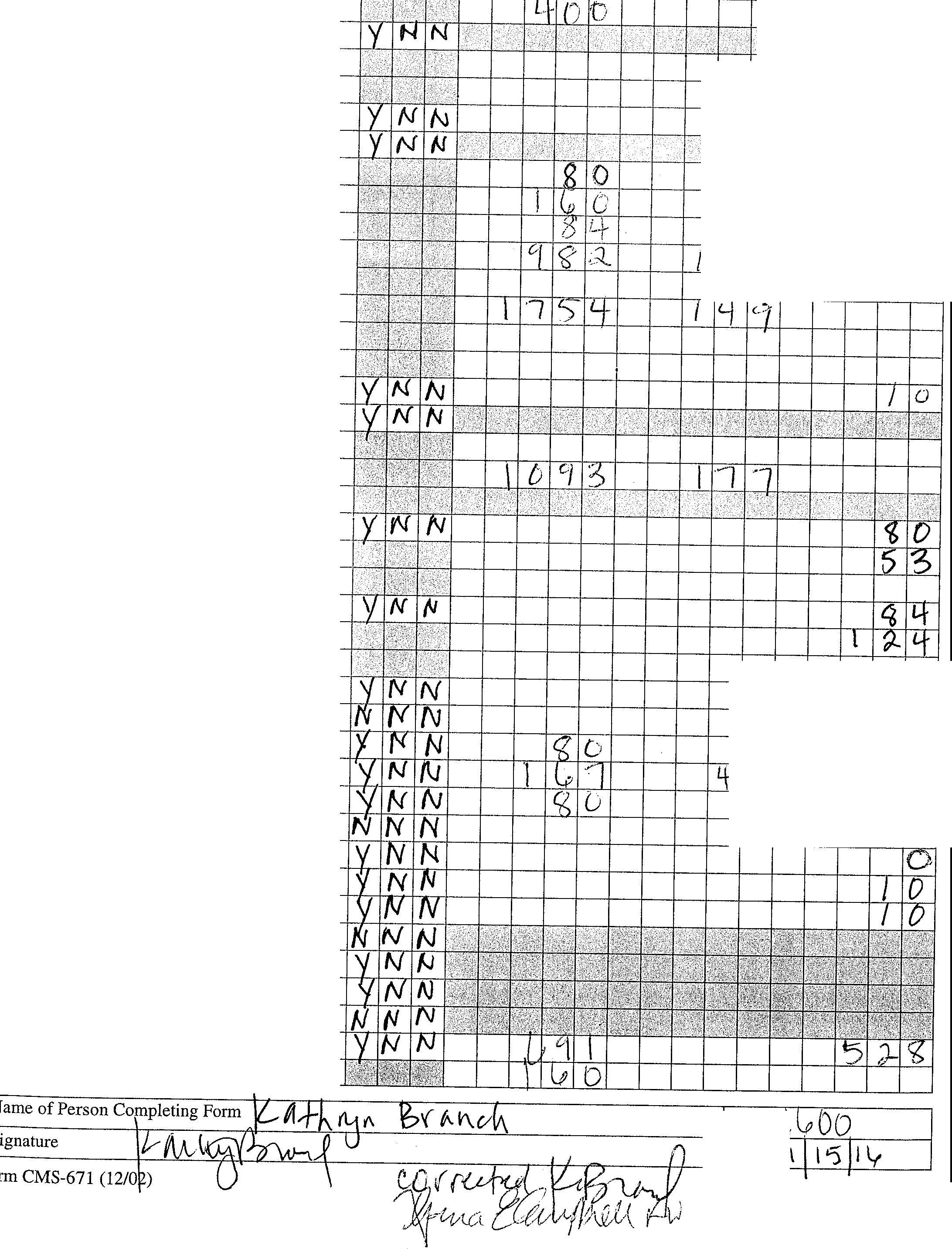
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Licensed Practical/ Licensed Vocational Nurses

F42 */5*

Certified Nurse Aides F43



Nurse Aides in Training F44

Medication Aides/Technicians F45

**Pharmacists** F46

**Dietary Services** F47

Dietitian F48

Food Service Workers F49

**Therapeutic Services** F50

Occupational Therapists F51 Occupational Therapy Assistants F52 Occupational Therapy Aides F53

Physical Therapists F54

Physical Therapists Assistants F55

Physical Therapy Aides F56

Speech/Language Pathologist F57 ?I

Therapeutic Recreation Specialist F58

Qualified Activities Professional F59

Other Activities Staff F60 4

Qualified Social Workers F61

Other Social Services F62

**Dentists** F63

**Podiatrists** F64

**Mental Health Services** F65

**Vocational Services** F66

**Clinical Laboratory Services** F67

**Diagnostic X-ray Services** F68

Administration & Storage of Blood F69

Housekeeping Services F70

Other F71

|  |  |
| --- | --- |
|  | Time |
|  | Date |

State of Viroinia

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i HINTED: 11/i712D16

FORM APPROVED

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIOER/SUPPLIER/CLIA. IDEMTIFICATION NUMBER.  **495410** | | | (X2) MULTIPLE CONSrnUCTION   1. BUILDING 2. WING -·--· | | | (X3 | J'DATE SURVEY COMPLETED  **11/17/2016** | |
| NAME OF PROVIDER OR SUPPLIER  AR LEIGH **BURKE PAVILION** | | | STREET ADDRESS, CITY,  **1739 KIRBY ROAD MC LEAN, VA 22101** | | | STATE, | ZIP CODE | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG 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) COMPLETE DATE |
| F ooo Initial Comments  An unannounced biennial State Licensure survey was conducted 11/15/16 through 11/16/16 Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.  The census in this 49 certified bed facility was 46 at the time of the survey. The survey sample consisted of 11 current resident reviews (Residents 1 through 11) and 4 closed record  reviews (Residents 12 through 15).  F 001 Non Compliance  The facility was out of compliance with the following state licensure requirements:  This RULE: is not met as evidenced by:  12 VAC 5 - 371 - 340 - cross references to the  federal deficiency 371  12 VAC 5 - 371 -180C (9)- cross references to the  federal deficiency 469 | | | | F 000  F 001 | | **RECE\VE.D**  NOV 29 20\G  **,,oH/OLC** | | | | |

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

STATE FORM 021100 X1MJ11 If conlinualion sheel 1 of 1



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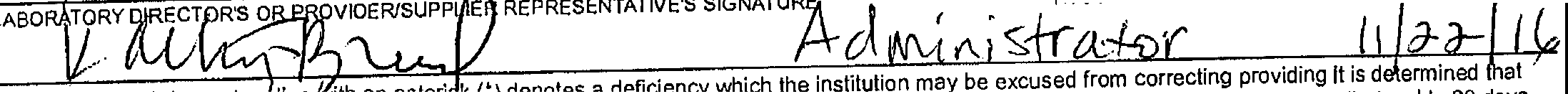
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| **11/16/2016** |
| f./Al,/,E OF PRO\/IOER OR SUPPLIER  **ARLEIGH BURKE PAVILION** | :,JTr,t,£T Al)DRESS, C1TY. STATE. ZIP CODE  '1739 KIRBY ROAD  **MC LEAN, VA 22101** | | | |
| (X4)IO SUMMARY STATEMENT OF DEFICIENCIES PREFIX {EACH OEFICIENC'( MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | 10  PREFIX TAG | PROVIOER'S PLAN OF CORRECTION JXS)  {EACH CORRECTIVE ACTION SHOULO BE COMPLETION  CROSS-REFERENCEO TO THE APPROPRIATE OATE  ' OEFICIENCY) | | |
| F 000 INITIAL COMMENTS  An unannounced Medicare/Medicaid standard survey was conducted 11/15/16 through 11/16/16. 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 46 at the time of the survey. The survey sample consisted of 11 current Resident reviews (Residents 1 through 11) and 4 closed record  reviews {Residents 12 through 15).  F 371 483.35{i) FOOD PROCURE,  SS=E STORE/PREPARE/SERVE - SANITARY  The facility must -   1. Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and 2. Store, prepare, distribute and serve food under sanitary conditions   This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview, and facility document review it was determined that the facility staff failed to store food in a safe manner and failed to ensure areas in the kitchen were free of pests.  The facility staff failed to label and date cheddar cheese when opened. | F 000  F 371 | F371 12/20/16  The bag of shredded cheese was discarded on 11/15/16.  A facility wide audit of all refrigerators and food storage areas has been completed with no additional infractions noted.  The facility policy and procedure related to food storage has been reviewed. All facility personnel responsible for labeling and dating of food have been in-serviced on proper food storage protocols.  All refrigerators and/or food storage equipment will be monitored as part of day and evening shift rounds by the dietary service manager and/or designee. In addition, a monthly audit will be perfor by the Director of Dietary Services. Any infractions noted will be reported to the QAPI committee for further monitoring and evaluation. | | |



Any dlciency statement Ing ith an asteri k (') denotes a deficiency which the institution may be excused from correcting providing It is d ermined at · others feguards provide sufficient protection I the palients. (See i11structions.) Except for nursing homes, the findings stated above are dlsclosable 90 days foliowi the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following \_the \_date these documents are made available to the facility. If deficiencies are cited, an approv rfiti quisile to continued

program part1cIpallon. **r\CvCI VCU**

FORM CMS-2567(02-99) P,eVious Versions Obsolete Event IO:U2PO11 Facility 10: VA0407 **NOV *2* 9** 2(}ffl-IInualion sheet Page 1 of 6

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|  | 1  STJ>.Tf:MENl oF oEF1c1ENc1Esl' (X, J r>Rov1OER(SUPPLiERFCUA t,ND PLAN OF CORRECTION 1OENTIFICATION NUMBER:  I 495410 | (X2) MULTIPLE CONSTRUCTION   1. BUILDING .\_.·\_. 2. WING --·· | | | (X3) DATE SURVEY COl·.1PLETEO |
| 11/16/2016 |
| NAME OF PROVIDER OR SUPPLIER  ARLEIGH BURKE PAVILION | | | STREET AOORESS. CITY. STATE, ZIP COOE  1739 KIRBY ROAD  **MC LEAN, VA 22101** | | |
| (X4)1O SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEOEO BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | 10  PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION IX5)  (EACH CORRECTIVE ACTION SHOULO BE COMPLETION  CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY) | |
| F 371 Continued From page 1  The findings include:  Observation was made of the kitchen on 11/1/516 at 7:35 a.m. accompanied by other staff member (OSM) #3, the dietary manager. The walk in refrigerator was observed. A five pound bag of shredded cheddar cheese was two thirds gone. The package was wrapped with plastic wrap.  There was no label or date of when the package was opened. OSM #3 looked at the package and stated it didn't have a date when opened. He read another label that stated it had been delivered on 11/7/16. When asked how long it was good for, OSM #3 stated, "Seven days." OSM #3, was asked if the cheese was still good, since the cheese was delivered on 11/7/16 and there is no date of when it was opened. OSM #3 stated, "You are correct. It has to be thrown away because seven days since delivery is yesterday and since we don't know when it was opened, it must be discarded."  The facility policy, "Labeling & Dating of All Food Items" documented in part, "Policy: All food items will be properly labeled and dated. Procedure: When any food item is opened or removed from the freezer, a proper label must be attached with that days date and the proper use by date using the following chart:  Refrigerator - Grocery items open - 7 days"  The administrator and director of nursing were made aware of the \_above findings on 11/15/16 at 4:25 p.m. | | F 371 | | F469 12/20/16  The facility dishroom was treated appropriately under the pest control program documentation. Any openings in the drywall  or tile noted in the dishroom were corrected  on 11/16/16.  A facility wide audit has been completed and no additional infractions were noted.  The facility has evaluated its pest control program I including responsiveness of the contractor. In addition the facility has evaluated the kit-chen cleaning schedule and made changes by development of cleaning logs to support daily, weekly and monthly cleaning schedules. All personnel responsible for the pest  cont ..Q.!\_program and kitchen cleaning  ***tf***  schedules have been in-serviced.  All cleaning schedules and kitchen equipment will be monitored as part of day and evening shift rounds by the dietary service manager and/or | |

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| STAT MF.NO: OF DEFICIENCIES AND PLAN Or- CORRECTION | (X1) 0PROViDER,'SUPPLIER/CLIA IDENTIFICATION NUMBER:  **495410** | iX2) MULTIPL  :f.. BUILDING  B. WING | | E CONSTRUCTION **r;;J DAlS SU VCY**  \_ COMPL.ETED  **11/16/2016** |
| NAME OF PROVIDER OR SUPPLIER  **ARLEIGH BURKE PAVILION** | | | STREET ADDRESS. CITY. STATE. ZIP CODE  **1739 KIRBY ROAD**  **MC LEAN, VA 22101** | |
| (X4)ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING (NFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION **(XS)**  [EACH CORRECTIVE ACTION SHOULD BE COMPLETION  CROSS-REFERENCED TO THE APPROPRIATE OAlE  DEF(CIENCY) |
| F 371 Continued From page 2  No further information was provided prior to exit.  F 469 483.70(h)(4) MAINTAINS EFFECTIVE PEST  SS=E CONTROL PROGRAM  The facility must maintain an effective pest control program so that the facility is free of pests and rodents.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview and review  of facility documentation it was determined the facility staff failed to have an effective pest control program in the kitchen of the facility, as evidenced by observation of a live roach in the kitchen trash can.  The findings include:  Observation was made on 11/15/16 at 7:40 a.m. of the dish room. A live roach, approximately one inch in length, not including antennae, was found crawling on top of the trash in the trash can.  OSM #7, a dietary employee, was in the area. She yelled for OSM #3, the dietary manager. When asked if she had seen any other roaches, OSM #7 stated, "I saw one yesterday crawling on the wall (pointing to the area above the sink and where dish racks were stored) but I washed him down the drain." When asked what she is supposed to do if she sees any bugs, OSM #7 stated, "I tell (OSM #3)." When asked if she told him about the roach yesterday, OSM #7 stated, "No." | | F 371  F 469 | | designee to ensure that standards and criteria are met. In addition, a monthly audit of the kitchen equipment and cleaning logs will be performed by the  Director of Dietary Services. Monthly monitoring of the facility's pest control program will be completed by the Director of Facilities. Any infractions noted will be reported to the QAPI committee for further monitoring and evaluation. |

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STATEMENT OF OEFICIENCIES (X1) PRDVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X:l) OATE SUf,''JF.Y I j

ANO PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

ARLEIGH BURKE PAVILION

IOENllF.ICATION,NUMBEP.: A. BUILOING

**495410** B. WING

STREET AODRESS. CITY. STATE, ZIP CODE

**1739 KIRBY ROAD**

**MC LEAN, VA 22101**

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11/16/2016

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SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)

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CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)

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F 469 Continued From page 3

Further observation of the dish room revealed the drain traps located near the floor of the room with open drywall around the drain traps. There was an open area of drywall above the right corner of the sink area, next to where the dishwasher dish racks are stored. This area was approximately seven inches by four inches. There were two cardboard bug traps found in the dish room, one at opposite corners of each other. Both were collapsed and were soaking wet with water.

The pest sighting book in the kitchen was reviewed. There was documentation of the roaches in the kitchen/dish room on 4/22/16, 6/7/16, 10/5/16and 10/12/16. A note was made on the 10/12/16 sighting "Requested upgraded treatment."

F 469

The pest control receipts were reviewed and documented the following:

"7/20/16 - Did not document the kitchen having been treated.

7/29/16 - Roaches in kitchen/dining area. Baited requested for roaches.

8/9/16 - Night Service - Dietary in its entirety.

8/17/16 - No documentation of the kitchen being treated

9/13/16 - Night Service - Dietary in its entirety 9/21/16 - Kitchen not documented as treated. 9/27/16 - Not the building that the kitchen was in. 10/3/16 - Roaches - kitchen, office, dish wash area.

10/11/16 - Night Service - Dietary in its entirety. 10/12/16 - Service for Roaches - time 9:00 p.m. Dietary in its entirety. A note documented, 'Treated for roaches. There was food found to be left out on trays. Trays were being brought in from the rooms while we were onsite for

FORM CMS-2567(02-99) Previous Vers;ons Obsolete Event 10: U2PO11 Facility 10: VA0407 If continuation sheet Page 4 of 6

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| s·rATEMENT OF OEFICIENCIES · P,ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IOENTIFICATION NUMBER:  495410 | (X2J MULTIPLE COi-lSTRUCi'iON   1. BUILDING 2. WING • | | | | | | (X3J DATE SURVEY COMPLETED  11/16/2016 | |
| NAME OF PROVIOER OR SUPPLIER  ARLEIGH BURKE PAVILION | | | STREET AOORES  1739 KIRBY RO  **MC LEAN, VA** | | S, CITY.  AD  **22101** | STATE, | ZIP COOE | | |
| (X4J 10 SUMMARY STATEMENT OF OEFICIENCIES PREFIX (EACH OEFICIENCY MUST BE PRECEOEO BY FULL  TAG REGULATORY OR LSC IOENTIFYING INFORMATION) | | 10  PREFIX TAG | | PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE  CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCYJ | | | | | (X5) COMPLETION OATE |
| F 469 Continued From page 4  treatment. Please keep in mind this is a calling card for roaches. We did not see any live roaches; however, we did see egress areas around the pipe chases. Suggest better cleaning around the corners in the prep area and the dishwashing room."  10/19/16 - Kitchen not documented as treated.  10/25/16 - Night service - Kitchen not documented.  10/26/16 - Not the building in which the kitchen  was in.  11/8/16- Not the building in which the kitchen was in.  11/8/16 - Night Service - Treated all areas, kitchen, lobby etc. Treated for roaches.  11/15/16- 8:46 a.m. Roaches. Dishwashing area. State Inspector on site. Baited for roaches in pot wash areas. Inspected the rest of the kitchen."  An interview was conducted with OSM #8, the pest control employee, on 11/15/16 at 9:45 a.m. He stated he had re-baited the kitchen and dish room. He stated he comes every second Tuesday in the middle of the night to do the treatment. When asked if he had seen any more roaches on his inspection of the kitchen, he stated he had not.  The facility policy, "Pest Control" documented in part, "Policy: If pests are seen in the kitchen, the food service manager or appropriate staff shall be informed, describing where the pest was seen and when. Appropriate action will be taken to eliminate any reported pest situation in the department. Procedure: 1. The contractor comes in to complete preventative spray treatments at the appointed times. 2. If a pest situation is reported, the contractor comes in to spray at the appointed times. The contractor will document | | F 469 | | | | | | | |

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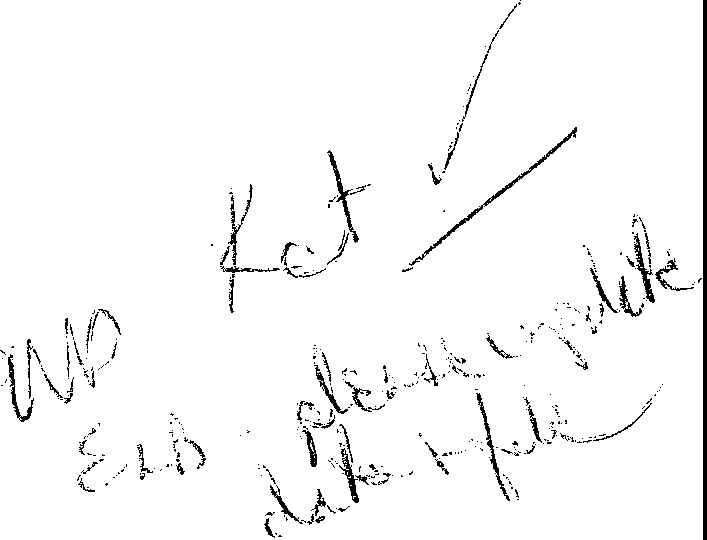
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| STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER'CLIA 77;2·1MULTIPL!o CONSTRUCTION {X1) O T·E S RV V- ,-  ANO PLAN OF CORRECTION .IOENTIFICATION NUMBER: A. BUILDING COMPLEH:D !  495410 B. WING 11/16/2016 | |
| NAME OF PROVIDER OR SUPPLIER  ARLEIGH BURKE PAVILION | STREET AOORESS, CITY, STATE, ZIP COOE  **1739 KIRBY ROAD**  **MC LEAN, VA 22101** |
| (X4) 10 SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIOER'S PLAN OF CORRECTION (XSi  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULO BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE QA.TE  OEFICIENCY) | |
| F 469 Continued From page 5 F 469 the visit along with action taken. 3. If the  contractor chemically treats lhe kitchen, all  dishes, pots pans, toasters, blenders, food processors, and other equipment must be covered. If these items are not covered during treatment, they must be washed and sanit[zed prior to use. 4. The contractor chemically treats the kitchen only after receiving consent from the food service manager. 5. Any pest traps In the kitchen area will be monitored every shift and disposed of according to the contractor's specifications."  The administrator and director of nursing were made aware of these findings on 11/15/16 at 4:25 p.m.  No further information was provided prior to exit. | |

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FORM CMS-2567(02-99) Previous Versions Obsolete Event IO:U2PO11 Facility 10: VA0407 If continuation sheet Page 6 of 6

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*MAKING* EVERY *MOMENT COUNT WITH DIGNITY, FRIENDSHIP* AND *SECURITY*

May 2, 2016

Virginia Department of Health Office of Licensure and Certification Attn: Ms. Wietske Weigel-Delano 9960 Mayland Drive, Suite 401

Richmond, VA 23233

Re: Notification of Administrator Change

Dear Ms. Delano:

I am writing to notify the Office of Licensure and Certification of the change in Administrators for facility Arleigh Burke Pavilion. Effective, May 2, 2016, Mr. Michael Hendee, license number 1701002614, will be the Administrator replacing Kathryn Branch, license number 1701002069 while she is on maternity leave. We will notify the office upon her return. If you have any additional questions please contact me directly at 703-538-2980 or [michaelh@vinsonhall.org](mailto:michaelh@vinsonhall.org)

Sincerely,

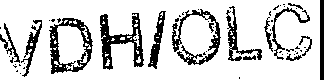
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Michael N. Hendee Chief Operating Officer

Vinson Hall Retirement Community

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