STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495410	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arleigh Burke Pavilion	1739 Kirby Road MC Lean, VA 22101

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 5. For Resident #18 (R18), the facility staff administered Amlodipine (1) outside of physician-ordered parameters multiple times in November and December 2024; and in January 2025. A review of R18's clinical record revealed the following order written 8/22/24: Amlodipine 5 mg (milligram) tablet 1 tablet by mouth every day. Hold for blood pressure less than 110/60. A review of R18's MARs (medication administration records) revealed Amlodipine was administered on the following days with the corresponding blood pressures: 11/4/24 - 120/57 11/11/24 - 115/53 11/16/24 - 118/56 12/10/24 - 119/57 12/11/24 - 126/59 12/15/24 - 129/59 12/17/24 - 129/59 1/5/25 - 128/59 1/13/25 - 121/53 1/14/25 - 117/59 A review of R18's care plan dated 11/18/24 revealed, in part: Resident will have no complications for cardiovascular disease and will not require outside medical intervention .Provide medication and treatment per physician's orders. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25 at 11:01 a.m., LPN (licensed practical nurse) #2 was interviewed. She stated if a resident has an order for a medication with blood pressure parameters, she stated the order should be reviewed, and the resident's blood pressure should be checked. She stated if the blood pressure readings are outside the parameters, the nurse should not give the medication, and document the reason in the clinical record. On 1/15/25 at 1:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the senior director of clinical services, and ASM #5, the chief operating officer, were informed of these concerns. A review of the facility policy, General Dose Preparation and Medication Administration, revealed, in part: Prior to administration of medication .facility staff should .verify each time a medication is administered that it is the correct medication, at the correct dose .confirm that the MAR (medication administration record) reflects the most recent medication order .if necessary, obtain vital signs. No additional information was provided prior to exit. Reference (1) Amlodipine (Norvasc) is used alone or in combination with other medications to treat high blood pressure in adults and children 6 years and older. It is also used to treat certain types of angina (chest pain) and coronary artery disease (narrowing of the blood vessels that supply blood to the heart). Amlodipine is in a class of medications called calcium channel blockers. It lowers blood pressure by relaxing the blood vessels so the heart does not have to pump as hard. It controls chest pain by increasing the supply of blood to the heart. This information is taken from the website https://medlineplus.gov/druginfo/meds/a692044.html. Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to ensure residents were free of unnecessary medications for five of 25 residents in the survey sample, R3, R6, R11, R22 and R18. The findings include: 1.The facility staff failed to ensure R3 was free of unnecessary medications by monitoring anticoagulant as ordered. R3 was admitted to the facility on [DATE] with diagnosis that included but were not limited to afib (atrial fibrillation). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/3/25, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers and bathing. Section N: anticoagulant- is taking, checked. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the comprehensive care plan dated 3/20/25 revealed, PROBLEM: At risk for bleeding secondary to use of anticoagulant medication-Eliquis. APPROACH: Ongoing monitoring for adverse effects such as unusual bruising, bloody or black tarry stools, red or dark brown urine, abdominal pain or swelling. Notify physician immediately if resident shows any of the above signs. A review of the physician's order dated 12/26/22 revealed, Eliquis 2.5 mg po twice daily. A review of the MAR (medication administration record) did not reveal evidence of anticoagulation monitoring. An interview was conducted on 1/15/25 at 9:00 AM with ASM (administrative staff member) #4, the Senior Director Clinical Services. When asked where to find the evidence of anticoagulation monitoring, ASM #4 stated, it should be on the care plan, we monitor it on the care plan. When asked where you would see evidence of anticoagulation monitoring by nursing staff, ASM #4 stated, in 30 years, I have not had that monitored, but we are looking into it starting it on the MAR. An interview was conducted on 1/15/25 at 10:30 AM with LPN (licensed practical nurse) #1. When asked what interventions if any are implemented for a resident on anticoagulants, LPN #1 stated, we monitor them for any bruising, bleeding or skin tears. When asked where the monitoring would be documented, LPN #1 stated, if we find something we document it in the progress notes. When asked if there is documentation that monitoring was completed, LPN #1 stated, the only documentation is when there is an issue. On 1/15/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the senior director clinical services were made aware of the above concerns. A review of the facility's Anticoagulation Protocol policy revealed, The nurse shall assess and document/report the following: Current anticoagulation therapy, including drug and current dosage. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. No further information was provided prior to exit. 2.The facility staff failed to ensure R6 was free of unnecessary medications by monitoring anticoagulant as ordered. R6 was admitted to the facility on [DATE] with diagnosis that included but were not limited to afib (atrial fibrillation), coronary artery disease and diabetes mellitus. The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 12/17/24, coded the resident as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers and bathing. Section N: anticoagulant- is taking, checked. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the comprehensive care plan dated 9/20/24 revealed, PROBLEM: At risk for bleeding secondary to use of anticoagulant medication-Eliquis. APPROACH: Ongoing monitoring for adverse effects such as unusual bruising, bloody or black tarry stools, red or dark brown urine, abdominal pain or swelling. Notify physician immediately if resident shows any of the above signs. A review of the physician's order dated 9/18/24 revealed, Eliquis 2.5 mg po twice daily. A review of the MAR (medication administration record) did not reveal evidence of anticoagulation monitoring. An interview was conducted on 1/15/25 at 9:00 AM with ASM (administrative staff member) #4, the Senior Director Clinical Services. When asked where to find the evidence of anticoagulation monitoring, ASM #4 stated, it should be on the care plan, we monitor it on the care plan. When asked where you would see evidence of anticoagulation monitoring by nursing staff, ASM #4 stated, in 30 years, I have not had that monitored, but we are looking into it starting it on the MAR. An interview was conducted on 1/15/25 at 10:30 AM with LPN (licensed practical nurse) #1. When asked what interventions if any are implemented for a resident on anticoagulants, LPN #1 stated, we monitor them for any bruising, bleeding or skin tears. When asked where the monitoring would be documented, LPN #1 stated, if we find something we document it in the progress notes. When asked if there is documentation that monitoring was completed, LPN #1 stated, the only documentation is when there is an issue. On 1/15/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the senior director clinical services were made aware of the above concerns. No further information was provided prior to exit. 3.The facility staff failed to ensure R11 was free of unnecessary medications by monitoring anticoagulant as ordered. R11 was admitted to the facility on [DATE] with diagnosis that included but were not limited to DVT (deep vein thrombosis), coronary artery disease and hypertension. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/28/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers and bathing. Section N: anticoagulant- is taking, checked. A review of the comprehensive care plan dated 8/28/24 revealed, PROBLEM: At risk for bleeding secondary to use of anticoagulant medication-Eliquis. APPROACH: Ongoing monitoring for adverse effects such as unusual bruising, bloody or black tarry stools, red or dark brown urine, abdominal pain or swelling. Notify physician immediately if resident shows any of the above signs. A review of the physician's order dated 11/8/24 revealed, Eliquis 5 mg po twice daily. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the MAR (medication administration record) did not reveal evidence of anticoagulation monitoring. An interview was conducted on 1/15/25 at 9:00 AM with ASM (administrative staff member) #4, the Senior Director Clinical Services. When asked where to find the evidence of anticoagulation monitoring, ASM #4 stated, it should be on the care plan, we monitor it on the care plan. When asked where you would see evidence of anticoagulation monitoring by nursing staff, ASM #4 stated, in 30 years, I have not had that monitored, but we are looking into it starting it on the MAR. An interview was conducted on 1/15/25 at 10:30 AM with LPN (licensed practical nurse) #1. When asked what interventions if any are implemented for a resident on anticoagulants, LPN #1 stated, we monitor them for any bruising, bleeding or skin tears. When asked where the monitoring would be documented, LPN #1 stated, if we find something we document it in the progress notes. When asked if there is documentation that monitoring was completed, LPN #1 stated, the only documentation is when there is an issue. On 1/15/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the senior director clinical services were made aware of the above concerns. No further information was provided prior to exit. 4.The facility staff failed to ensure R22 was free of unnecessary medications by monitoring anticoagulant as ordered. R22 was admitted to the facility on [DATE] with diagnosis that included but were not limited to afib (atrial fibrillation) and coronary artery disease. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 10/4/24, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assistance for mobility/transfers and bathing. Section N: anticoagulant- is taking, checked. A review of the comprehensive care plan dated 10/10/24 revealed, PROBLEM: At risk for bleeding secondary to use of anticoagulant medication-Eliquis. APPROACH: Ongoing monitoring for adverse effects such as unusual bruising, bloody or black tarry stools, red or dark brown urine, abdominal pain or swelling. Notify physician immediately if resident shows any of the above signs. A review of the physician's order dated 9/30/24 revealed, Eliquis 5 mg po twice daily. A review of the MAR (medication administration record) did not reveal evidence of anticoagulation monitoring. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 1/15/25 at 9:00 AM with ASM (administrative staff member) #4, the Senior Director Clinical Services. When asked where to find the evidence of anticoagulation monitoring, ASM #4 stated, it should be on the care plan, we monitor it on the care plan. When asked where you would see evidence of anticoagulation monitoring by nursing staff, ASM #4 stated, in 30 years, I have not had that monitored, but we are looking into it starting it on the MAR. An interview was conducted on 1/15/25 at 10:30 AM with LPN (licensed practical nurse) #1. When asked what interventions if any are implemented for a resident on anticoagulants, LPN #1 stated, we monitor them for any bruising, bleeding or skin tears. When asked where the monitoring would be documented, LPN #1 stated, if we find something we document it in the progress notes. When asked if there is documentation that monitoring was completed, LPN #1 stated, the only documentation is when there is an issue. On 1/15/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the senior director clinical services were made aware of the above concerns. No further information was provided prior to exit.