STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495114	A. BUILDING _____ B. WING _____	C 08/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF ARLINGTON, LLC	1785 SOUTH HAYES STREET ARLINGTON, VA 22202

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated Survey was conducted 08/12/19 through 08/13/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 240 certified bed facility was 173 at the time of the survey. The survey sample consisted of two current resident reviews (Resident #2 and Resident #3) and one closed record review (Resident #1).	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed follow a physician's order for a wound vac treatment for a sacral pressure for one of 3 residents in the survey sample, Resident #2.	F 686	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 2 indicated in the 2567 was not adversely affected by the alleged	8/31/19

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

Electronically Signed | 08/22/2019

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

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F 686	Continued From page 1 Findings include: Resident #2 was admitted to the facility 6/7/19. Diagnoses for this resident included, but were not limited to: ESRD (end stage renal disease) dependent on hemodialysis, CHF (congestive heart failure), DM (diabetes mellitus), atrial fibrillation, cardiomyopathy, high blood pressure, leiomyosarcoma, stage 4 sacral pressure ulcer and a history of VRE (vancomycin resistant enteroccoci). The most current MDS (minimum data set) was a significant change assessment dated 8/1/19. This MDS assessed the resident with a cognitive score of 12, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as requiring extensive to total assistance for all most all ADL's (activities of daily living) with assistance of one to two staff members. The resident was additionally assessed as having a colostomy, and as "always" being incontinent of urine. This MDS assessed the resident with a stage 4 pressure ulcer (present upon admission). Resident #2 was interviewed on 8/13/19 at 9:30 AM. Resident #2 confirmed that he had a pressure ulcer and had a wound vac. A wound vac was observed on the resident's night stand. The wound vac was running and was set at 125 mmhg (millimeters of mercury) continuous, but the tubing was not attached to the resident, it was attached to the machine. Resident #2 was asked about the wound vac not being attached. Resident #2 stated that it wasn't connected to him and that RN (Registered Nurse) # 1 unhooked him from it yesterday prior to dialysis, which was	F 686	deficient practice has had his chart reviewed and care plan updated as appropriate. A physician order was received on 8/15/19 for a wet-to-dry dressing until seen by Wound Care physician on 8/16/19. The wound care physician saw the resident 8/16/19 and his note indicates the sacral wound is stable. A care conference was held with the resident (present) and his fiancé (by phone) on 8/15/19. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A review of other residents to determine if anyone else was using a wound vac (negative pressure equipment) was completed on 8/14/19 by the unit managers and wound care nurses. There were no other residents in the facility at this time using a wound vac. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility policy and procedure on Wound Vac Care and Treatment, Skin Integrity and Pressure Ulcers will be reviewed and updated as appropriate and if so changed the appropriate staff will be informed of same and educated on the changes. The Director of Nursing/Assistant Director of Nursing or their designated representative is providing education and training of nurses and nursing assistants	

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F 686	Continued From page 2 around 2:00 PM. Resident #2 was asked why it was disconnected and why he wasn't able to go to dialysis with the wound vac. Resident #2 stated that he normally does go to dialysis with the wound vac and he wasn't sure why it was disconnected. He stated that he thought he had the wound vac for about month, maybe a little longer. Resident #2 stated that RN #1 unhooked it and stated that she would come back and hook it back up, but she never did. He stated that he goes to dialysis Monday, Wednesday, Friday and also stated that is when his dressing changes are. Resident #2 stated that he didn't think the nurse put another dressing on his wound when she disconnected the wound vac. Resident #2's current physician's orders were then reviewed. Resident #2 had an order for: "Cleanse sacrum with wound cleanser, pat dry apply wound vac 125 mmhg q [every] mon-wed-fri every day shift every Mon, Wed, Fri. Start Date: 6/12/19..." Resident #2's current CCP (comprehensive care plan) was reviewed and documented, "...self care deficit...related to pressure ulcer...totally dependent on one staff for personal hygiene...dressing...toilet use...has actual impairment to skin integrity related to stage 4 pressure wound of his sacrum...at risk for further breakdown due to ESRD, limited mobility...cleanse sacrum with wound cleanser, pat dry apply wound vac 125 mmhg q mon-wed-fri...keep skin clean and dry..." The progress notes were reviewed. Observed was a late entry nursing note that was dated 8/13/19 10:41 AM, and also had an effective date of 8/12/19 10:36 AM. The nursing note	F 686	on the proper use and monitoring of wound vac (negative pressure equipment) and the care of same when not in use and their roles related to same. In-servicing began on 8/13/19. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Residents with wound vac treatments are discussed daily M-F by Nursing Team (DON/ADON, Unit Managers, Wound Nurses, Dietitian & other disciplines as appropriate). Any skin related issues from weekends are discussed in the Monday morning clinical team meeting. All residents with wound vacs will be audited 3 x per week for 4 weeks to ensure physician orders are followed. Weekly x 4 weeks and report findings to the monthly QA committee to ensure compliance. The nurse management team will then perform random audits monthly thereafter to ensure orders are being followed. Results of the audits will be reported to the QA committee monthly x 3 months to review and determine what, if any additional interventions are needed at the end of the 3 month period.	

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documented, "Writer went into residents room to complete wound care, resident was getting ready for dialysis. Writer received verbal order from physician to apply dry dsg [dressing] to sacral wound which was implemented...signed by RN #1."

At 11:00 AM, RN #1, who was also a wound nurse, was interviewed regarding the above information and observation. RN #1 stated that she saw the resident yesterday around 2:40 PM and that a CNA (certified nursing assistant) had called her into the room because the resident was getting ready to go to dialysis. RN #1 stated that she put a dry dressing on the residnet's sacral wound because he needed to go to dialysis. RN #1 stated that the facility has two wound care nurses. RN #1 stated that she was doing assessments/new admissions yesterday and the other wound nurse, LPN (Licensed Practical Nurse) #4 was doing treatments and stated, "I guess she didn't get to see him."

RN #1 was asked why Resident #2 couldn't go to dialysis with his wound vac. RN #1 stated that he always goes to dialysis with the wound vac and that LPN #4 hadn't gotten to him to put it on. RN #1 then stated that the wound vac was beeping and alarming and he needed to go to dialysis. RN #1 was asked why the wound vac dressing wasn't done. RN #1 stated that the wound vac dressing hadn't been done, so she put on the dry dressing and that the wound vac dressing change takes about 15 or 20 minutes. RN #1 stated that LPN #4 was supposed to do the wound vac dressing change for Resident #2 and that is what they discussed that morning.

At 11:15 AM, LPN #4 was interviewed. LPN #4

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stated that she and RN #1 normally do this floor together and further stated that they normally do Resident #2's dressing change together. LPN #4 stated that RN #1 was doing assessments/new admissions yesterday and that she (LPN #4) was supposed to have done Resident #2's dressing change, but she left early due to not feeling well and stated, "[Name of RN #1] went ahead and did his treatment for me." LPN #4 was made aware that Resident #2's wound vac dressing did not get done yesterday as ordered by the physician. LPN #4 stated that RN #1 told her that she was going to do the dressing. LPN #4 stated that she left the facility around 2:00 PM. LPN #4 was asked if we could look at Resident #2's dressing to see what the resident had on at this time.

At approximately 11:25 AM, Resident #2 was rolled onto his side by LPN #4 and CNA #8 to observe the dressing in place. Resident #2 had a dressing in place that was completely saturated, barely adhereing to the wound area. The dressing was a a dry square dressing with a tape border that measured approximately 6 x6 inches. The dressing had the date of 8/12 with 7-3 also written on it, but no time documented. The wound had a copious amount of drainage.

LPN #4 stated that she was going to do the wound vac dressing change now. LPN #4 gathered the supplies and changed the resident's wound vac dressing.

At approximately 11:55 AM, the administrator and NP (nurse practitioner) were made aware of concerns regarding Resident #2's wound and dressing, specifically the amount of drainage the resident's wound was producing and concerns that the resident's wound vac dressing was not in

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place.

At approximately 2:05 PM, Resident #2 was again observed. Resident #2 stated that staff had taken care of him. His wound vac dressing was applied and the machine was attached, with visible drainage sitting in the the tubing. The display screen was observed and revealed that the machine was on, but not functioning. The display read, "On Hold" and "Alarm Silenced."

At approximately 2:10 PM, RN #1 was asked to observe the wound vac machine. RN #1 looked at the machine and stated that she did not know what was wrong or why the machine was on hold or the alarm silenced, and stated that it was on earlier. RN #1 pushed the button to start the machine and stated, "It may start to beep." The machine was started and immediately suction began and drainage was moving in the tubing, no beeping or alarms were sounding.

At 2:15 PM, RN #1 was asked if she had reported to the physician yesterday that the resident's wound vac was not on. RN #1 stated, "I spoke with the doctor today and I implemented the treatment yesterday; I called the doctor this morning and he said it was ok." RN #1 was asked for clarification and was asked if she implemented the treatment first, which was yesterday and then called the physician today. The RN stated, "Yes."

At 4:25 PM, the administrator, ADON (assistant director of nursing) and the DSW (director of social work) were informed of the above concerns with Resident #2, that the resident's wound vac dressing was not implemented per physician's orders, and that RN #1 failed to notify the

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physician.

A policy was requested on wound vac care and treatment.

A policy was presented titled, "Negative Pressure Wound Therapy" documented, "...To promote healing of various types of wounds..negative pressure wound therapy will be provided in accordance with physician orders, including the desired pressure setting, continuous or intermittent therapy, and frequency of dressing change...is considered an advanced wound therapy and is usually initiated when other modalities have proven unsuccessful or to prevent complications in high risk situations...shall be used only when the goal is wound healing...chronic open wounds with depth...full thickness wounds...in accordance with manufacturer's recommendations...Monitoring throughout the use...shall include...device is functioning...troubleshooting of any alarms...response of therapy...progress towards healing...Whenever therapy cannot be resumed within two hours, remove the dressing and apply a moist wound dressing. Notify physician for specific orders...The physician shall be notified of any complications associated with the use of NPWT (negative pressure wound therapy)..."

At 5:35 PM, the ADON stated that RN #1 wanted to clarify regarding her late entry nursing note. RN #1 stated that she did talk to the doctor regarding the dressing change and that the doctor agreed to the dressing and that she implemented the dressing change yesterday. RN #1 stated, "I put a dry dressing on and he (doctor) agreed, I didn't call him (doctor) until today. RN #1 then stated that the nursing note should have

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F 686	Continued From page 7 been timed for 2:40 PM, not 10:40 AM. No further information and/or documentation was presented to evidence that the faciltiy staff followed the physician's order and residnet's plan of care for the treatment of a stage 4 pressure ulcer wound with wound vac therapy.	F 686		