10-05-16 16:50 FROM- Regency Care of Arli 703-979-8190

		E & MEDICAID SERVICES			OMB NO. 0938-039
STATEMEN	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495114	B. WING		R-C 09/22/2016
NAME OF	PROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP COD	
REGEN	CY CARE OF ARLING	TON, LLC	ı	5 SOUTH HAYES STREET LINGTON, VA 22202	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
(F-000)		TS	(F 000)	_	
	standard survey cowas conducted 9/1 complaints were in Significant correction compliance with the Care Requirements are identified within deficiencies are identified within deficiency are identified within deficiencies are identified within deficience are identified within deficiencies are identified within defic	()(1) DEVELOP CARE PLANS the results of the assessment and revise the resident's in of care.  velop a comprehensive care	{F 279}	This plan of correct respectfully submit evidence of allege. This submission is admission that the existed or that we agreement of them affirmation that could the areas cited have and that the facility compliance with prequirements.  F-Tag 279  Criterion #1- Concept Resident # 103 so assessment was considered.	tted as d compliance into an deficiencies are in i. It is an orrections to be been made by is in participation  orrection moking completed on
	plan for each reside objectives and time medical, nursing, ar	int that includes measurable tables to meet a resident's and mental and psychosocial lified in the comprehensive		Resident # 103 si plan initiatéd and on 9/21/16	noking care individualized
	to be furnished to all highest practicable (	describe the services that are tain or maintain the resident's physical, mental, and		RECEIVE	
	§483.25; and any se	eing as required under ervices that would otherwise		UL 05 2016	
		483.25 but are not provided exercise of rights under		0CT 0 5 2016 <b>VDH/OLC</b>	<b>b</b>

OF PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

TITLE

(X6) DATE

Any deliciency statement ending with an asterisk (\*) denotes a deliciency which the institution may be excused from correcting providing it's 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB NO. 0938-0391

PRINTED:	09/3/0/2016
	APPROVED
	ASSES BEEN

CENTERS STATEMEN" OF AND PLAN UP C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTITUTION	B) DATE SURVEY COMPLETED R-C
		495114	B. WING_		09/22/2016
	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1785 SOUTH HAYES STREET ARLINGTON, VA 22202	
(X4) ID PREFIX TAG	/EACH DESIGENO	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	(X5) COMPLETION TE DATE

(F 279) Continued From page 1

§483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on resident interview, staff interview, clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to develop a CCP (comprehensive care plan) for one of 18 residents in the survey sample (Resident # 103).

The facility staff failed to develop a CCP (comprehensive care plan) for Resident # 103 regarding smoking.

Findings include:

Resident # 103 was admitted to the facility on 07/20/16, with the most current readmission on 08/19/16. Diagnoses for Resident # 103 included, but were not limited to: anemia, HTN (high blood pressure), pneumonia, asthma, cellulitis of the right lower extremity and right knee replacement, and osteoarthritis.

The most current MDS (minimum data set) with CAAS (care area assessment summary) was a 14 day admission assessment, dated 09/02/16. This MDS assessed the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills The resident was also assessed as requiring extensive assistance for transfers and ambulation.

A complaint investigation was conducted on 09/19/16 through 09/22/16. The complaint

(F 279)

Criterion #2- Other Potential

A 100% audits of all care plans of current residents who have been identified as smokers will be reviewed and revised by Social Services to ensure accurate information and intervention are addressed.

A 100% audits of all smoking assessments of current residents who have been identified as smokers will be reviewed by Social Services to ensure accurate information in the medical record.

Criterion #3- System Change Licensed nursing staff and Social Services staff will be reeducated on the importance of completing and/or revising the comprehensive care plan and smoking assessment. Social Services will maintain an updated list of smokers. Any new residents who are admitted will be advised that the facility is a smoke free center per facility policy.

The care plan will be updated as the resident's ability to smoke changes.

(K1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

PRINTED 09/30/2016 FORMAPPROVED

09/22/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES	3
CENTERS FOR MEDICARE & MEDICAID SERVICES	

OMB NO 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A BUILDING R-C

	8 WING	1
495114	Q AAUAO	
	STREET ADDRESS CITY STATE, ZIP CODE	

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

REGENCY CARE OF ARLINGTON, LLC

1785 SOUTH HAYES STREET ARLINGTON, VA 22202

OF(2/X)PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(XS) COMPLETION DATE

(F 279) Continued From page 2

alleged that the facility does not ensure smoking safety for residents.

On 09/20/16 at 3:50 a.m., Resident # 103 was interviewed in his room, with his wife present. The resident had a partial pack of cigarettes on the night stand beside his bed. The resident was asked about the cigarettes. The resident stated that he is a smoker, although he was trying to quit. The resident was asked if he goes outside to smoke alone. The resident stated that staff will ask me where I am going most of the time if they see me coming down the hall and I tell them I'm going to smoke and they will go with me. The resident stated, "She (pointing to his wife) goes with me most of the time." The resident further stated that there are specific times of when smoke breaks are. The resident was then asked if he ever went outside alone to smoke. The resident stated that, as a matter of fact he had went out last night (09/19/16) by myself and that he "got caught", the resident voiced that it was a little later than usual and his favorite nurse had caught him.

Resident # 103's clinical record was reviewed. No smoking assessment could be located within the clinical record.

The resident's current CCP was reviewed. No information was found on the resident's CCP regarding smoking.

The resident's current/active POS (physician's order sheet) was reviewed and documented, ...May participate in supervised field trips.. " No information was found on the POS regarding smoking

{F 279}

#### Criterion #4- Monitoring

Weekly x 6 and every-otherweek x 6 Social Services or designee will monitor the residents who smoke to ensure all smoking assessments and care plans remain up to date. Weekly x 8 ADON/designee will randomly audit 5 smoking assessments and care plans to ensure they are completed and updated. Analysis of the audits will be given to the OA Committee for additional oversight and recommendation.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

703-979-8190

T-855 P0005/0045 F-623

PRINTED: 09/30/2016 FORM APPROVED

DEPARTM	ENTOF	HEALTH.	AND F	MAMUE	SERVICES	ŝ
CENTERS						

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	COMPLETED R-C
V Jorgen	495114	B. WING	· · · · · · · · · · · · · · · · · · ·	09/22/2016
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF ARLING	FON, LLC	17	TREET ADDRESS, CITY, STATE, ZIP CODE 785 SOUTH HAYES STREET RLINGTON, VA 22202	
(FACH DEFICIENC	TEMENT OF DEFICIENCIES  MUSY BE PRECEDED BY FULL  SC ICENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TO BE COMPULTION

(F 279) Continued From page 3

On 09/20/16 at 10:45 a.m., the DON (director of nursing) was asked for the facility's smoking policy

The smoking policy was presented and reviewed. The policy documented, "Policy and Procedure Topic, Smoking...Date initiated: 09/01/16...The facility promotes a safe, healthy and smoke free environment...Residents who resided at the facility prior to August 11, 2016, and who smoked will continue to have the right to smoke at the facility following safe smoking protocols .. 1. Prior to admission and during the admission process, the resident and/or responsible party will be advised in writing of the facility smoking policy. 2. The resident's desire to smoke and any needed assistance/supervision will be addressed in the resident's comprehensive plan of care...the facility does not allow for residents to keep any flammable smoking materials in their room...4. identified resident (sic) who wishes (sic) to utilize the designated outdoor smoking areas will be assessed by the nursing department using the Safe Smoking Assessment..."

On 09/20/16 at approximately 4:00 p.m., in a meeting with the survey team, the administrator, DON (director of nursing) and the ADON (assistant director of nursing) were asked, where the smoking assessments were located for residents. The DON pointed to the computer and stated that they were in the computer. The above staff were informed that a smoking assessment could not be located for Resident # 103 and that the resident's CCP did not mention smoking.

On 09/21/16 at approximately 3:50 p.m., the DON, administrator and ADON were again made aware of concerns regarding the above

(F 279)

10-05-16 16:51 FROM- Regency Care of Arli 703-979-8190 PRINTED: 09/30/2016 DEPART MENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLÉTED AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING R-C B WING 09/22/2016 495114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1785 SOUTH HAYES STREET REGENCY CARE OF ARLINGTON, LLC ARLINGTON, VA 22202 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID CK41 ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) YAG TAG DEFICIENCY) (F 279) (F 279) Continued From page 4 information. The DON stated, that the resident did not tell them (facility staff) that he smoked and further stated that a smoking assessment had been completed and that information was on the CCP. The information was presented to this surveyor. This surveyor asked, if the DON if the assessment and care plan was completed after bringing it to the facility's attention on 09/20/16. The DON stated, "Yes." No further information or documentation was presented prior to the exit conference on 09/22/16 at 10.45 a.m. to evidence that Resident # 103 was assessed by facility staff to ensure the F-Tag 280 resident was safe to smoke and no evidence was Criterion # 1 Correction found to evidence that a CCP was developed for Resident #112 care plan was Resident # 103 in regards to smoking. revised on 10/3/16 to address stage 3 pressure injury This is a complaint deficiency. ⟨F 280} 483.20(d)(3), 483.10(k)(2) RIGHT TO {F 280} development, goals, and current SS=D PARTICIPATE PLANNING CARE-REVISE CP interventions. Criterion #2 Other Potential

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to

participate in planning care and treatment or

changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility. for the resident, and other appropriate staff in disciplines as determined by the resident's needs. and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed

A 100% audit of care plans for residents with pressure ulcers will be done to ensure care plans are completed, reviewed and revised as needed.

Criterion # 3-System Change Licensed nursing staff and MDS Coordinators will be reeducated on the importance of reviewing and revising the care plan to reflect resident's condition changes and current interventions.

703-979-8190

P0007/0045 F-623 T-855

> PRINTED: 09/30/2016 FORMAPPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND FLAN OF CORRECTION A. BUILDING \_ R-C B. WING. 09/22/2016 495114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1785 SOUTH HAYES STREET

REGENCY CARE OF ARLINGTON, LLC

ARLINGTON, VA 22202

074:10 PREED TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

10 PRÉFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(XS) COMPLETION DATE

(F. 280). Continued From page 5

and revised by a team of qualified persons after each assessment

{F 280}

This REQUIREMENT is not met as evidenced bv:

Based on resident interview, staff interview, clinical record review, facility document review and during the course of a complaint investigation the facility staff failed to review and revise the CCP (comprehensive care plan) for one of 18 residents. (Resident # 112).

The facility staff failed to review and revise the CCP for Resident # 112 in the area of pressure ulcers.

Findings include:

Resident # 112 was admitted to the facility on originally on 03/11/16, with the most current readmission on 07/05/16. Diagnoses for Resident # 112 included, but were not limited to: PVD (peripheral vascular disease), atrial fibrillation, ESRD (end stage renal disease) requiring hemodialysis, and arthritis

The most current MDS (minimum data set) was a significant change assessment dated 09/05/16. This MDS assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact. The resident was also assessed as requiring extensive assistance with dressing, toileting, hygiene and bathing, with assistance of at least one staff member physical assist. The resident triggered in the CAAS (care area assessment summary) section for pressure

Criterion # 4-Monitoring

A weekly audit of 6 care plans for residents with pressure ulcers will be done x 6 weeks and then a random sample of 5 residents weekly x 4 weeks and then at least 2 residents weekly x 4 weeks by MDS Coordinator/designee to ensure that the care plan appropriately addresses pressure ulcer care. Finding will be reported to DON/ADON for trends and patterns. Analysis of the audits will be given to the QA Committee for additional oversight and recommendation.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

PRINTED: 09/30/2016 FORM APPROVED

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				0.0938-0391
COMPANY OF THE PROPERTY OF THE	3 333304 33300 4767	& MEDICAID SERVICES	CYSLEMEN	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD		1	MPLETED
					1	R-C
		495114	8. WING			2/22/2016
NAME OF F	PROVIDER OR SUPPLIER		-	STREET ADORESS, CITY, STATE, ZIP CODE		nada an ang mara
DO CENT	Y CARE OF ARLING	TON, ELC		1785 SOUTH HAYES STREET ARLINGTON, VA 22202		
KEGENO				PROVIDER'S PLAN OF CORREC	CTION	(X5)
(XA) ID PREFIX TAG	(BACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTION SHO	DULD BE	COMPLETION DATE
en de la composition de la composition La composition de la			M		***************************************	
(F 280)	Continued From pa	ge 6	{F 2	80}		
	og/19/16 at 4:00 puthere is a absence as changing briefs, needs to be change use the call bell to twill tell me (residen you already, you wistated that it is con. The resident was a The resident stated was then asked if hand was informed cresident had a large the resident stated that he felt like the shift had contribute bottom. The resident was then asked if he shift. The resident was then asked if he (rearea was from staff shift. The resident was then asked if he bottom. The resident was then asked if he tottom. The resident was then asked if he tottom. The resident was then asked if he tottom. The resident # 112's cl. A "Skin Observation reviewed dated 07/	with Resident # 112 on m, the resident stated that of care on the night shift as far. The resident stated that if he ed on the night shift, he will tell them (staff) and that staff (t) that we (staff) have changed II have to wait. The resident sistently on the night shift, sked, how this made him feel. It is provided the had a bruise on his bottom of a complaint that alleged the e bruised area over his bottom of a complaint that alleged the element of the could not see it, but coloration. The resident stated staff not changing him on night do to the condition of his ent was asked to clarify, and sident) thought the bruised finot changing him on the night stated, "Yes." The resident stated, "Yes." The resident he had any open areas on his ent stated, "Yes."  In Tool-Licensed Nurse" was 12/16 and timed 6:30 p.m.				

documented:

concern on the body. The form also had a description area to the right of the body image that described skin conditions in detail, which

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/30/2016 FORM APPROVED

DEPART	MENT OF HEALT	A MEDICALD SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES  (X1) PROVIDER'SUPPLIER'CLIA IDENTIFICATION NUMBER:	3	ILTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANG PLAN 0	F CORRECTION	IDENTIFICATION NOMBERS		DING	R-C
		495114	B. WING	***	09/22/2016
NAME OF F	ROVIDER OR SUPPLIER	**************************************		STREET ADORESS, CITY, STATE, 21	P CODE
garages on garage g fr	Y CARE OF ARLING	TON LLC		1785 SOUTH HAYES STREET	
REGENC	Y CARE OF ARLING	1014, EE0		ARLINGTON, VA 22202	
(X4) ID PREFIX TAG	JEACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX (EACH CORRECTIVE ACTI	ION SHOULD BE COMPLETION THE APPROPRIATE DATE
Parameter sette se	The second secon	A. A			
(F 280)	Continued From pa	ige 7	{F 2	280)	
	localized area of difilled bilster due to tissue from pressur be preceded by tiss boggy, warmer or dissue. Stage I-Intaredness of a localiz prominence Stage dermis presenting ared pink wound bet III-Full thickness tis may be visible but not exposed. Slou not obscure the de undermining and to thickness tissue los or muscle. Slough present Unstagea in which the base of slough (yellow, tan eschar (tan, brown Below this area on document the site in number), the type (width, depth, and site of the following: "Wo as ordered."	able-Full thickness tissue loss of the ulcer is covered by gray, green, or brown) and/or or black) in the wound bed" the form was an area to (area on the body with (type of wound/area), length,			

resident was offered a low air mattress prior to the stage III and that the resident refused.

The resident's CCP (comprehensive care plan) was reviewed and documented, "... Bathing and DEPARTMENT OF HEALTH AND HUMAN SERVICES

RIN	red: 09/30/2016	
FC	DRM APPROVED	
MB	NO. 0938-0391	

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES	TY11 PROVIDER/SUPPLIER/CLIA	1	INCE CONZUMPCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	(DENTIFICATION NUMBER.	A. BUILDII	vG	R-C
A. A. C.	495114	B. WING		09/22/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADORESS, CITY, STATE, ZIP CODE	
REGENCY CARE OF ARLING			1785 SOUTH HAYES STREET ARLINGTON, VA 22202	
(X4)*D SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF CORRECTS	0.40

# (F 280) Continued From page 8

Showering: (03/12/16) Avoid scrubbing and pat dry sensitive skin...provide sponge bath when a full bath or shower cannot be tolerated. Bed mobility: The resident requires limited assistance by (1) staff to turn and reposition in every two hours and as necessary...Resident is totally dependent on (1) staff for dressing..requires extensive assistance by (1) staff for personal hygiene...totally dependent on (1) staff for toilet use... Anticipate and meet the resident's needs...The resident needs prompt response to all request for assistance...monitor wound healing progress...encourage good nutrition and hydration in order to promote healthier skin...keep skin clean and dry..." No further information was located on the resident's CCP regarding pressure ulcer prevention interventions.

Resident # 112 was interviewed again on 09/21/16 at 8:50 a.m., the resident stated that he did not like the air mattress and specifically named the bed an air maxx. The resident stated that staff had ordered one and put on his bed back in March, when he was first admitted. The resident stated that the mattress would get air pockets in it and it was extremely difficult for him to move at all. The resident stated that he felt like he was in a hole and he did not feel like that was good for him. The resident was asked if he could move and turn himself. The resident stated that he needed assistance from staff because of his dialysis graft in his left arm, he was not suppose to put a lot of pressure or weight on that arm and that he has weakness and can't really turn himself very well. The resident stated that he felt like a new, regular type of mattress would be better for him.

Resident # 112's nutrition/dietary information was

(F 280)

OCCUPANT OF HEA! THAND HUMAN SERVICES

PRINTED: 09/30/2016 FORM APPROVED

UEFARI	WIENT OF THEME	A MEDICALD CEDVICES				OMB NO	<u>). 0938-0391</u>
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION		TE SURVEY MPLETED
AND PLAN O	FCORRECTION	DENTIFICATION NUMBER:	A. BUILI	JING	and the state of t	ſ	R-C
		495114	B. WING		and the state of t	09	0/22/2016
NAME OF F	ROVIDER OR SUPPLIER			1	ET ADDRESS, CITY STATE, ZIP CODE		
				1	SOUTH HAYES STREET		
REGENC	Y CARE OF ARLING				INGTON, VA 22202 PROVIDERS FLAN OF CORREC	TIÓN	(X5)
(X4) IÛ PREFIX TAG	ZEZICH DEEXCHENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	IEACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	COMPLETION DATE
este distribution de la company de la compan	, manufactured or more high transporting manufacture of more or more o						
(F 280)	Continued From pa	age 9	{ <b>F</b> ∶	280}			
	then reviewed.						
	RD (Registered Di- 07/10/16. This ass resident has a sign 30, 90, and 180 da typically consumes assessment addition resident required effor walking and did feeding himself. No listed and the asse- resident had wountoes. This assessing resident was high in		t				
	RN (Registered No documented that the 76-100% and had multiple impaired a injury. This form d	ssessment completed by the urse) # 4, dated 09/02/16 he resident had intake of a stage tII/VI pressure ulcers or areas, suspected deep tissue lid not include any additional assessed the resident as a	ર્પ				
	p.m.,which docum Resident # 112) to support wound her him at all times an	etary note on 09/01/16 at 6:11 ented: "Visited with (name of discuss recommendations to elingpretein bars available to dine was encouraged to eat at support wound healing"					
	The RD was interval, m, regarding Re	riewed on 09/21/16 at 10:15 sident # 112. The RD was					

asked how often are residents seen the RD stated that is based on their risk. The RD was made aware that Resident # 112 was assessed as a high risk on 07/10/16, five days after his

PRINTED, 09/30/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING R-C B. WING 09/22/2016 405114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1785 SOUTH HAYES STREET REGENCY CARE OF ARLINGTON, LLC ARLINGTON, VA 22202 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) :D (EACH CORRECTIVE ACTION SHOULD BE LEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG ..DEBICIENCY) (F 280) (F 280) Continued From page 10 readmission on 07/05/16. The RD was asked if an albumin had been obtained for Resident # 112. The RD stated that an albumin, is really not a useful determination of nutritional status, as it once was. The RD was asked, she would order something like an albumin. The RD stated, no and went on to say the physician would normally order that. The RD was asked if she collaborates with the resident's physician in regards to wound healing strategies. The RD stated, "Not really." No specific nutritional recommendations were found for Resident # 112 on the 07/101/6 nutritional assessment. The resident's CCP was reviewed and documented to monitor the resident's intake, liberalize diet, and to monitor for decreased appetite. No other nutritional interventions were found for Resident # 112. The administrator, DON (director of nursing) and ADON were made aware of concerns regarding Resident # 112 being found with a stage III and that the resident's CCP did not reflect sufficient or adequate interventions for the prevention and or F-Tag 309 treatment of the resident assessed high risk skin. Criterion #1-Correction (F. 309). 483.25 PROVIDE CARE/SERVICES FOR {F 309} Resident #111 has not SS=D HIGHEST WELL BEING demonstrated any adverse outcome from not receiving his Each resident must receive and the facility must

provide the necessary care and services to attain or maintain the highest gracticable physical. mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

pain medicine as ordered. Resident has received pain medication as ordered by physician since 9/20/16. The physician was notified of the pain medication that had not been documented as having been administered

# DEPARTMENT DE HEALTH AND HUMAN SERVICES

PRINTED: 09/30/2016 FORM APPROVED

DEPARTMENT OF MEALIN				0	VIB NO.	0938-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER.		TIPLE CONSTRUCTION	4	(X3)0ATE	,
AND PEAN OF CORRECTION	495114		, , , , , , , , , , , , , , , , , , ,		R- 09/2	C 2/2016
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF ARLINGT				CITY STATE, ZIP CODE ES STREET		
COSES LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	10 PREF TAG	IX (EACH CC	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD FERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
and in the course of facility staff failed to medication administ in the survey sample. The facility staff failed pain medication (Fellydromorphone) with physician's order for Findings include:  Resident # 111 was originally in 2014, with readmission on 09/Resident # 111 inclumational metanom tymphocytic leukem blood and bone matery disorder, included and bone mat	rview, clinical record review f a complaint investigation, the ofollow physician's orders for tration for one of 18 residents in the error (Resident # 111).  ed to ensure Resident # 111's entanyl patch and as administered per in Resident # 111.  admitted to the facility with the most recent 103/16. Diagnoses for unded, but were not limited for the (a metastatic cancer), aira (a type of cancer or the most), seizure disorder, somnia (inability to sleep), and cognitive problems) and ess, numbness and	{F : }	Cri A l cur resi ava Cri Nur edu com phy	iterion # 2-Other Pot 00% audit will be done rent residents to ensur idents have their medi- itable.  Iterion # 3-System Classing staff will be re- cated on the important immunicating with the sician and pharmacy of ilability of medication ing ordered.	ne for re all cations  hange ace of	

During a complaint investigation on 09/19/16 through 09/22/16, Resident # 111's clinical records were reviewed. A complaint was investigated regarding Resident # 111, with an

10-05-16 16:52 FROM- Regency Care of Arli DEPART MENT OF HEALTH AND HUMAN SERVICES

703-979-8190

T-855 P0014/0045 F-623

FORMAPPROVED OMR NO. 0938-0391

CENTERS	S FOR MEDICARE	8 MEDICAID SERVICES			
STATEMACHT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED R-C
		495114	8. WING		09/22/2016
	CARE OF ARLING		17	REET ADDRESS, CITY, STATE, ZIP CODE 85 SOUTH HAYES STREET RLINGTON, VA 22202	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION

<del>(F 309)</del>

(F 309) Continued From page 12

allegation that the resident was in pain, when visited by family on 09/16/16 though 09/18/16 and that the resident did not receive pain medication in a timely manner.

Resident # 111's current POS (physician's order set) was reviewed and documented the resident had orders for the pain medication, including but not limited to a Fentanyl patch 12 mcg (micrograms)/hour every 72 hours. This medication start date was 09/04/16 (discontinue on 09/17/16 at 12:41 a.m.), a Fentanyl patch 25 rneg/hour every 72 hours, which was suppose to start on 09/18/16 at 9:00 a.m. and for Hydromorphone (dilaudid) 4 mg (milligrams) every 4 hours PRN (as needed).

A nursing note (ORDER NOTE) dated 09/17/16 and timed 12:46 a.m. documented that the Fentanyl 25 mcg patch/hr apply 1 patch every 72 hours order, had been put into the computer system.

A Nursing note (Orders Administration Note) was reviewed and cocumented on 09/17/16 at 1:22 a.m., "N/A [not available/not administered] at this time."

The resident's MARs (medication administration records) were reviewed for September 2016. It was documented on the MAR for September 17th at 0122 (1:22 a.m.) that the Fentanyi 12 mcg patch was removed.

A nursing note (Orders Administration Note) dated 09/17/16 and timed 10:34 a.m. documented, "Pharmacy will send medication. Resident is comfortable tolerated PRN (as needed) pain med well."

## Criterion # 4- Monitoring

Daily x 2 weeks, 3x week x 2 weeks, and then weekly x 6 weeks, 5 current residents and 5 new admissions/re-admissions orders will be validated by Unit Managers and/or designee to ensure availability of ordered medications. Variances will be investigated and corrections made as appropriate. Findings will be given to DON/ADON for tracking of patterns. An analysis of the weekly audits will be provided to the QA Committee for additional oversight and recommendation.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

P0015/0045 F-623 10-05-16 16:52 FROM- Regency Care of Arli 703-979-8190 PRINTED: 09/30/2016 FORMAPPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (XZ) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPFLIER/CLIA STATEMENT OF DEPICIENCIES COMPLETED AND PLAN OF CORRECTION DENTIFICATION NUMBER A. BUILDING R-C 09/22/2016 B WING. 495114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1785 SOUTH HAYES STREET REGENCY CARE OF ARLINGTON, LLC ARLINGTON, VA 22202 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID. 054640 (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (F 309) Continued From page 13 The resident's MARs were further reviewed and documented that Resident # 111 did not get his Fentanyl 25 mcg patch until 3:35 p.m. on 09/20/16, over 3 days later. No Fentanyl 25 mcg patch was in place for approximately 81 hours. Additional review of the resident's MARs for PRN (as needed) pain medication administration did not evidence that any PRN pain medication was administered from 09/17/16 through 09/18/16 The PRN pain medication (dilaudid 4 mg) was administered, according to the MAR on 09/19/16 at 7:05 p.m., approximately 41 hours later. The resident's CCP (comprehensive care plan) was reviewed and documented, ".. The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs...all staff are to converse with resident while providing care...administer medications as ordered...The resident has lump under the R (right) armpit (has dx (diagnosis) of CLL [chronic lymphocytic teukemia]...Administer analgesics as per MD [medical doctor] orders...Give pain meds as ordered...The resident has pain r/t [relate to] leukemia, history of dvt (deep vein thrombosis),

ordered...The resident has pain r/t [relate to] leukemia, history of dvt (deep vein thrombosis), chronic pain syndrome...anticipate the resident's need for pain relief and respond immediately to any complaint of pain...monitor/record/report to nurse any s/sx [signs/symptoms] of non-verbal pain: changes in breathing...vocalizations...mood/behavior .reside nt prefers to have pain controlled by dilaudic...encourage non-pharmacological interventions...encourage support system of

The DON (director of nursing), administrator,

family and friends..."

10-05-16 16:52 FROM- Regency Care of Arli 703-979-8190

DEPARTMENT OF HEALTH AND HUMAN SERVICES

T-855 P0016/0045 F-623

PRINTED: 09/30/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	8 MEDICAID SERVICES				<u>MB NO. 0938-0391</u>
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONS ING		(X3) DATE SURVEY COMPLETED
		495114	B. WING			R-C 09/22/2016
NAME OF	PROVIDÉR OR SUPPLIER			STREET	DORESS, CITY, STATE, ZIP CODE	, , , , , , , , , , , , , , , , , , ,
				1785 SO	UTH HAYES STREET	<b>y</b>
REGENC	CY CARE OF ARLING	TON, LLC	1	ARLING	TON, VA 22202	
(X4) ID PREFIX TAG	(ÉACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
(F 309)	Continued From pa	ge 14	{F 30	09}		
	corporate nurse we with the survey teal regarding the allegates Resident # 111 did medications in a time. No further informate presented prior to \$6.09/22/16 at 10.45 at # 111 received his p	on or documentation was he exit conference on .m., to evidence that Resident pain medication in a timely or				
	as ordered by the p	hysician.				_
	This is a complaint	deficiency.			F-Tag 312	
	483.25(a)(3) ADL C DEPENDENT RES	ARE PROVIDED FOR IDENTS	F 3	112	Criterion # 1- Correct	ion
Seed Seed Seed	A resident who is us daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal			Resident # 104 has not demonstrated any adveroutcome. On 9/20/16 re 104 was assisted with no	eident #
					Criterion # 2- Other Po	tential
	by. Based on observatinterview, clinical reinvestigation, the fairingernal care for o	ion, resident interview, staff cord review and complaint cility staff failed to provide the of 18 residents in the			A 100% audit of current residents will be conduct Unit Managers/Designee ensure nails are clean and trimmed as appropriate.	ted by
	survey sample. Re- with long, dirty finge	sident #104 was observed rnails.			Criterion # 3-System Cl	hange
	The findings include Resident #104 was 3/19/16 with a re-ad Diagnoses for Resid	admitted to the facility on mission on 7/1/16.			Direct care staff will be re educated on when, how as who can provide nail care the importance of providing	nd and
	Diagnoses for Resid	reta #104 incl00e0			care.	

:0-05-16 16:53 FROM- Regency Care of Arli DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

703-979-8190

P0017/0045 E-623

2	1.00	$\alpha \alpha$	COTO	ŧ	Sal Same
	FO	DRM	APPRO	DV	ÉD
	OMB	NO.	.0938-	03	91

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X)) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

495114

(X2) MULTIPLE CONSTRUCTION A. BUILDING ....

(X3) DATE SURVEY COMPLETED R-C

09/22/2016

NAME OF PROVIDER OR SUPPLIER

REGENCY CARE OF ARLINGTON, LLC

STREET ADDRESS CITY, STATE, ZIP CODE 1785 SOUTH HAYES STREET ARLINGTON, VA 22202

(X≦) COMPLETION DATE

CHILD PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ΙĐ PREFIX TAG

8 WING

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

#### F 312 CONTINUED From page 15

Parkinson's disease, end stage renal disease, chronic obstructive pulmonary disease (COPD), diabetes and high blood pressure. The minimum data set (MDS) dated 7/20/16 assessed Resident #104 as cognitively intact. This MDS listed Resident #104 required the extensive assistance of one person for hygiene.

On 9/20/16 at 8:00 a.m. Resident #104 was observed in bed. The resident had tremors/shaking of both hands that the resident stated was due to her Parkinson's disease. Resident #104's fingernails on each hand were long extending approximately 1/4 inch beyond the end of her fingertips. There was a black substance under the 3rd and 4th fingernali of the resident's left hand. Resident #104 was interviewed at this time about her fingernalls. Resident #104 stated her nails were extremely long and needed to be cut. Resident #104 stated she did not want long nails but wanted them inmmed/cleaned.

Resident #104's plan of care (revised 9/1/16) documented the resident required assistance with performing activities of daily living due to her disease processes. Care plan interventions to meet activity of daily living needs included, "Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse."

On 9/20/16 at 8:05 a.m. accompanied by licensed practical nurse (LPN) #1, Resident #104's fingernalis were observed. LPN #1 was interviewed at this time about the condition of Resident #104's nails. LPN #6 stated she would have to get with the head nurse to see who was supposed to cut the resident's halfs.

## Criterion # 4- Monitoring

Weekly x 6 weeks 6 current residents' nails per unit will be checked by unit managers and/or designee to ensure nail care is being provided. Findings will be given to DON/ADON for tracking patterns. Variances will be corrected. An analysis of the weekly audits will be provided to the QA Committee for additional oversight and recommendation.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

FORM CMS-2587(02-99) Previous Versions Obsolete

Event 10:0MV812

Pacility IO: VA0186

Hicontinuation sheet Page 16 of 44

10-05-16 16:53 FROM- Regency Care of Arli 703-979-8190 DEPARTMENT OF HEALTH AND HUMAN SERVICES

T-855 P0018/0045 F-623

FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u> DMB NO. 0938-0391</u>
STATEMEN	T OF DEPICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		495114	8 WING		R-C 09/22/2016
HAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2IP CODE	
REGEN	CY CARE OF ARLING	TON, LLC		1785 SOUTH HAYES STREET ARLINGTON, VA 22202	
(XA) ID PREFIA TAG	(EACH DEFICIENC)	CEMENT OF DEFICIENCIES  CMUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERÊNCED TO THE APPROI DEFICIENCY)	MOTES 38 Q.
o o o o o o o o o o o o o o o o o o o	Continued From pa	00.16		12	
- Comment of the comm	<del>- Саннаво гтон р</del> а	i <del>ge ro</del>	1 2	12	
	manager (RN #3) v Resident #104's lor the nurse aides we #3 stated for some required to cut nails RN #3 stated the na trim and clean her f	-			
	meeting on 9/20/16	at 4 00 p.m.			
F 314	This was a complaid 483.25(c) TREATM	-	F 3	F-Tag 314	
SS=G	PREVENT/HEAL P	RESSURE SORES		Criterion # 1-Corr	ection
	resident, the facility who enters the facility who enters the facilities not develop prindividual's clinical of they were unavoidal pressure sores received.	rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having rives necessary treatment and healing, prevent infection and rom developing.		Treatment plan for r #112 was re-evaluat the best course of th prevent and heal pre	ted to ensure eatment to
				Criterion # 2- Other	Potential
	by: Based on resident clinical record review and during the courthe facility staff faile for the prevention of	interview, staff interview, w, facility document review se of a complaint investigation d to ensure skin assessments f a Stage III pressure ulcer for (Resident # 112) resulting in		A 100% Skin assessing Sweep" will be done to skin integrity is being maintained and treatmental be re-evaluated for residents who have presidents.	ent "Skin 0 ensure ent (s) 1 current

10-05-16 16:53 FROM- Regency Care of Arli

DEPARTMENT OF HEALTH AND HUMAN SERVICES

703-979-8190

P0019/0045 F-623 T-855

FORM APPROVED

PRINTED: 09/30/2016

CENTER	<u>S FOR MEDICARE</u>	<u>&amp; MEDICAID SERVICES</u>			<u>OMB NO</u>	<u>. 0938-039</u>
	TEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A BUILDING  495114  B WING  STREET ADDRESS, CITY, STATE  GENCY CARE OF ARLINGTON, LLC		1	E SURVEY MPLETED		
		495114	B WING		Į	R-C <b>/22/20</b> 16
NAME OF PROVIDER OR SUPPLIER STRE		STREET ADDRESS, CITY, STATE, ZIP (	CODE			
REGENCY	CARE OF ARLING	FON, LLC		1785 SOUTH HAYES STREET ARLINGTON, VA 22202		•
(XI) IÕ PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED YO THE DEFICIENCY)	A SHOULD BE	(X3) COMPLETION OATE

F 314 Continued From page 17

F 314

The facility staff failed to complete a weekly, full body skin assessment on Resident # 112 for over 6 weeks, as a result a Stage III pressure ulcer was found on the resident on 08/29/16.

#### Findings include:

Resident # 112 was admitted to the facility on originally on 03/11/16, with the most current readmission on 07/05/16. Diagnoses for Resident # 112 included, but were not limited to: PVD (peripheral vascular disease), atrial fibrillation, ESRD (end stage renal disease) requiring hemodialysis, and arthritis.

The most current MDS (minimum data set) was a significant change assessment dated 09/05/16. This MDS assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact. The resident was also assessed as requiring extensive assistance with dressing, toileting, hygiene and bathing, with assistance of at least one staff member physical assist.

During an interview with Resident # 112 on 09/19/16 at 4:00 p.m., the resident stated that there is a absence of care on the night shift as far as changing briefs. The resident stated that if he needs to be changed on the night shift, he will use the call bell to tell them (staff) and that staff will tell me (resident) that we (staff) have changed you already, you will have to wait. The resident stated that it is consistently on the night shift. The resident was asked, how this made him feel. The resident stated, "Pissed off!" The resident was then asked if he had a bruise on his bottom. and was informed of a complaint that alleged the

# Criterion #3-System Change

Licensed nursing staff will be re-educated on how to identify and document skin issues

Licensed Nursing staff will be re-educated on prevention of pressure ulcer Licensed Nursing staff will be re-educated on how to check the computer dashboard for alerts on issues relating to skin integrity and what to do when an alert is present.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

703-979-8190

T-855 P0020/0045 F-623

PRINTED: 09/30/2016 FORM APPROVED

CENTERS	S FOR MEDICARE	8 MEDICAID SERVICES			OIMB NO	<u>. 0938-0391</u>
STATEMENT O AND FLAN OF	F DEACIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUU A BUILDI	TIPLE CONSTRUCTION NG	COM	ESURVEY MPLETED R-C
		495114	8, WING		09	/22/2 <b>0</b> 16
NAME OF PR	CVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REGENCY	CARE OF ARLING	TON, LLC		1785 SOUTH HAYES STREET ARLINGTON, VA 22202		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE

#### F 314 Continued From page 18

resident had a large bruised area over his bottom. The resident stated, that he could not see it, but there had been discoloration. The resident stated that he felt like the staff not changing him on night shift had contributed to the condition of his bottom. The resident was asked to clarify, and was asked if he (resident) thought the bruised area was from staff not changing him on the night shift. The resident stated, "Yes." The resident was then asked if he had any open areas on his bottom. The resident stated, "Yes."

Resident # 112's clinical records were reviewed.

Nursing notes were reviewed and documented the following:

08/29/16 (2:53 p.m.) "Resident is alert and verbally responsive. Able to make needs known. Routine nursing care provided,...Resident left for dialysis this after noon around 1415 [2:15 p.m.] in stable condition. No acute distress noted upon departure..."

08/29/16 (3:09 p.m.) "Assigned CNA [certified nursing assistant] reported to the wound nurse that the resident has an open area. Resident was assessed by the wound nurse and the writer. Circular shape open area 1 cm [centimeters] in length and 0.8 cm in width noted on resident's right upper buttock. No drainage, nor bleeding, slight slough noted. Resident c/o [complained of] mild pain. Or. [name of physician] was notified—frequent turning and positioning was through out this shift..."

08/29/16 (5:55 p.m.) "new skin area observed on a [sic] resident Rt [right] upper buttock (stage 3) MD [medical doctor]. new order give..."

F 314

#### Criterion # 4-Monitorimg

2x weekly x 4 weeks and then weekly x 8 weeks, 6 residents' skin will be assessed randomly by Unit Managers and/or designee. Discrepancies will be addressed.

Weekly x 12 weeks, the DON/ADON and/or designee will observe 5 residents' skin condition. Any discrepancies will be addressed.

On a monthly basis, the ADON/designee will forward the findings to the QA committee for review.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

FORM CMS-2567(02-99) Previous Versions Obsorere

Event ID:0MV812

Facility ID: VA0166

If continuation sheet Page 19 of 44

P0021/0045 F-623 T-855 703-979-8190 10-05-16 16:53 FROM- Regency Care of Arli DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/30/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO.</u> 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORPECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLEYED R-C 495114 B. WING 09/22/2016 NAME OF PROVIDER OR SUPPLIER SYREET ADDRESS, CITY, STATE, ZIP CODE REGENCY CARE OF ARLINGTON, LLC 1785 SOUTH HAYES STREET ARLINGTON, VA 22202 SUMMARY STATEMENT OF DEFICIENCIES (X4)10 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (85) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) FAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) f 314 Continued From page 19 F 314 Resident # 112's wound records were then reviewed.

A "Skin Observation Tool-Licensed Nurse" was reviewed dated 07/12/16 and timed 6:30 p.m.

This form had a picture of a human body, with numbers corresponding to 52 different areas over the body to accurately identify the location of concern on the body. The form also had a description area to the right of the body image that described skin conditions in detail, which documented:

"Suspected Deep Tissue Injury-Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by lissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Stage I-Infact skin with no-blanchable redness of a localized area usually over a bony prominence...Stage II-Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough...Stage II-Full thickness lissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV [4]-Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present. Unstageable-Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed..." Below this area on the form was an area to document the site (area on the body with

\*0-05-16 16:54 FROM- Regency Care of Arli

703-979-8190

P0022/0045 F-623 PRINTED: 09/30/2016

DEFICIENCY)

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIEP/CLIA IDENTIFICATION NUMBER.	(X2) MULT A BUILDII	" (6 60).01.00.10.	(X3) DATE SURVEY COMPLETED R-C
		495114	8 WING		09/22/2016
NAME OF PE	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
RECENCY	CARE OF ARLING	TON, LLC		1785 SOUTH HAYES STREET ARLINGTON, VA 22202	
(A4) ID PREFIX	(EACH DEFICIENC	PTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCHOENTIETHING INFORMATION)	D PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETION

F 314 Continued From page 20

TAG

number), the type (type of wound/area), length, width, depth, and stage

REGULATORY OR LISC IDENTIFYING INFORMATION)

This form (dated 07/12/16) above described area was blank, section 2 under "Notes" documented the following: "Wound care treatment continues as ordered."

The skin observation tool form dated 08/29/16 was then reviewed and documented "Site: 31 Right buttock Type. Pressure Length: 2 [cm] Width: 1.5 Depth: [no depth was documented] Stage: III., Notes: new skin area observed on a [sic] resident Rt upper buttock (stage 3) MD...notified new order given. 50% G [granulation tissue] 50 % S [slough]..."

LPN (Licensed Practical Nurse) # 1, also known as the wound nurse was interviewed on 09/21/16. at 8:10 a.m. LPN # 1 was asked if weekly skin. assessments are done. LPN # 1 stated, yes and they are completed by the floor nurses and are called "Skin Observation Tool-Licensed Nurse." The LPN stated that she does an initial assessment on admission and whenever there is a brand new area found. LPN #1 stated that once an area is found, she will take care of the wound, by notifying the physician, rounding with the wound clinic if that is ordered for a resident. completing measurements regarding progress. and dressing changes for that particular wound. per the physician's orders. LPN # 1 stated that the floor nurses are responsible for the full body weekly skin assessment.

The LPN was asked to look at Resident # 112's full body skin assessments. LPN # 1 pulled up the Skin Observation Tool forms located in the electronic clinical record. The LPN was made

F 314

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0MV812

Fachly ID: VA0186

If continuation sheet Page 21 of 44

10-05-16 16:54 FROM- Regency Care of Arli 703-979-8190

DEPARTMENT OF HE	ALTH AND HUMAN SERVICES		FORM APPROVED OMB NO. 0938-0391
CENTERS FOR MEDI- STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CARE & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495114	(X2) MULTIPLE CONSTRUCTION  A. SUILDING  B. WING	(X3) DATE SURVEY COMPLETED R-C 09/22/2016
NAME OF PROVIDER OR SUF	PUER	STREET ADDRESS, CITY, ST 1785 SOUTH HAYES STRI	EET
SOUTH FACH DEE	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL LY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECT! TAG CROSS-REFERENCE	AN OF CORRECTION (X5)  IVE ACTION SHOULD BE COMPLETION ED TO THE APPROPRIATE DATE  FICIENCY)
was complete aware that overbalized that nurses  LPN # 1 was III pressure unto assess it was asked herself and wanything could LPN # 1 state the resident's report it to another the resident's LPN # 5, also interviewed at the resident's LPN # 5 state asked where the computer tool form; the	e last one done prior to the stage I and on 07/12/16. The LPN was mader 6 weeks had passed since the ent was completed and now the a stage III. The LPN again at these are done by the floor asked about Resident # 112's stage licer and how this was found. LPN was reported on 08/29/16 by CN was slough and necrotic tissue, and that she and the floor nurse were and notified the physician. LPN # bw this went from nothing to a stage that she started to investigate ent into the computer to see if did be found.  If that she had found where CNA did in the computer on 08/18/16 that bottom was red, but she did not	ge #AA  nt 1 ge ::  for ts.  in n st	

Both LPN's were reviewed the electronic clinical record and became aware that no full body skin assessments could be located for Resident # 112 after 07/12/16. Both LPN's agreed that the last

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/30/2016 FORM APPROVED

CENTE	RS FOR MEDICARI	8 MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495114	8. WING		R-C 09/22/2016
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, 2IP CODE	
REGENC	CY CARE OF ARLING	TON, LLC		85 SOUTH HAYES STREET RLINGTON, VA 22202	
(X4) IO PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCEO TO THE APPR DEFICIENCY)	OLD BE COMPLÉTION
F 314	Continued From pa	age 22	F 314		
	·	or to finding the stage III on	, 0, ,		
	assessments should should documented LPN # 5 was asked POC. The LPN state and it triggers for the didn't know why the LPN # 1 stated that	t the weekly full body ld be done weekly and that it d in the POC (plan of care). It to clarify what she meant by ited that it is in the computer he nurses to complete, but she ey were not completed. It the resident was offered a			
		or to the stage III and that the PN # 1 was asked for dates ess refusal.			
	document anything buttock skin conditi	e again reviewed and did not regarding Resident # 112's on, in the days leading up to estage III, on 08/29/16.			
		aluation form was reviewed is form documented an area tht second toe.			
		aluation form dated 08/18/16 form documented an area on			
		aluation form dated 03/25/16 form documented an area on			
	was reviewed. This on the right upper b	aluation form dated 09/02/16 form documented the area uttock, as acquired pressure granulation tissue and			

necrotic tissue was present.

T-855 P0025/0045 F-623

PRINTED: 09/30/2	016
FORM APPROV	/ED
OMB NO 0938-03	391

		M AND HUMAN SERVICES				APPROVED: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER.	A BUILD	INĠ	1	R-C
		495114	B. WING			/22/2016
VAME OF	PROVIDER OR SUPPLEE	₹		STREET ADDRESS, CITY, STATE, ZIP COI	)£	
		2*0b 11.6		1785 SOUTH HAYES STREET		
REGENO	Y CARE OF ARLING	310N, LEC		ARLINGTON, VA 22202		
(X1; iD PREFIX TAG	(EACH DEFICIEN)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	AMAMA ACCOMMOCO TO THE AL	HOULD BE	IXS) COMPLETION DATE
F 314	Continued From p	page 23	F3	314		
		P (comprehensive care plan)				
	was reviewed and	I documented, "Bathing and				
	Showering: (03/1	2/16) Avoid scrubbing and pat				
	dry sensitive skin.	provide sponge bath when a				
		r cannot be toleratedBed dent requires limited assistance				
	From the residence of the form	and reposition in every two				
	hours and as nece	essary. Resident is totally				
	dependent on (1)	staff for dressing, requires				
	extensive assistar	nce by (1) staff for personal				
	hygienetotally de	ependent on (1) staff for toilet				
	useAnticipate ar	nd meet the resident's				
	needs The reside	ent needs prompt response to istancemonitor wound healing				
	an requestion ass	age good nutrition and hydration	1			
	in order to promot	e healthier skinkeep skin				
	clean and dry" I	No further information was				
	located on the res	ident's CCP regarding pressure				
	ulcer prevention in	nterventions.				
	A Documentation	survey report for August 2016 CNA documentation. In the				
	Was reviewed for the Skip observation in	t was documented on 08/01/16				
		the resident had a discoloration				
	to the skin (no loc	ation specified). On 08/11/16 it				
	was documented	the resident had a red area (no				
		18/16 it was documented that				
	the resident had a	red area (no location). On				
	08/24/16 it was do	ocumented that the resident had				
	discoloration (no l	ocation). On 08/26/16 it was				
		the resident had a red area (no 29/16 it was documented that				
		in open area (no location).				
*		as interviewed again on a.m., the resident stated that he				
		mattress and specifically				

named the bed an air maxx. The resident stated that staff had ordered one and put on his bed

10-05-16 16:54 FROM- Regency Care of Arli 703-979-8190

T-855 P0026/0045 F-623 PRINTED: 09/30/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORMAPPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES		· A AND COMPANY TO AN	(X3) DATE SURVEY		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	WLDE DEFICIENTIES IN LONDERS AND THE PROPERTY OF THE PROPERTY		CONSTRUCTION	COMPLETED		
AND FLAN OF COMPRESSION		7. 00,000.00		R-C		
	495114	8 WING		09/22/2016		
NAME OF PROVIDER OR SUPPLIER			PEET ADDRESS, CITY, STATE, ZIP CODE			
		1	85 SOUTH HAYES STREET			
REGENCY CARE OF ARLING	TOW, ELC		RLINGTON, VA 22202	ETION (X5)		
(A4) NO CACO DESIGNED	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OUTD BE COMPLETION		
F 514 Continued From page 1	age 24	F 314				
back in March, wh	en he was first admitted. The					
resident stated tha	at the mattress would get air was extremely difficult for him					
pockets in it and it	e resident stated that he felt like	2				
he was in a hole a	nd he did not feel like that was					
good for him. The	eresident was asked if he could	Í				
move and turn him	nself. The resident stated that ince from staff because of his					
he needed assista	left arm, he was not suppose					
to but a lot of pres	sure or weight on that arm and					
that he has weakn	iess and can't really turn					
himself very well.	The resident stated that he felt					
like a new, regular better for him.	r type of mattress would be					
Resident # 112's r then reviewed.	nutrition/dietary information was	;				
A nutritional risk a	ssessment, completed by the					
RD (Registered D	ietitian) was reviewed dated	5				
07/10/16. This as	sessment documented that the nificant weight loss over the las	: St				
resident has a sig	ays and that the resident					
typically consume	s an average of 50%. The					
assessment addit	ionally documented that the					
resident required	extensive assistance from staff	•				
for walking and di	d not have any problems					
feeding himself. I	No albumin information was essment documented that the					
listed and me ass	Comment Godon to the arrest time					

resident was high risk.

resident had wounds on his right 2nd and 5th toes. This assessment documented that the

A nutritional risk assessment completed by the RN (Registered Nurse) # 4, dated 09/02/16 documented that the resident had intake of 76-100% and had a stage III/VI pressure ulcers or multiple impaired areas, suspected deep tissue injury. This form did not include any additional

10-05-16 16:54 FROM- Regency Care of Arli

DEPARTMENT OF HEALTH AND HUMAN SERVICES

703-979-8190

P0027/0045 F-623

FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARI	E & MEDICAID SERVICES		The second secon	1	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
VMD bevitte. country ion.	Charles Co. C. S. Sylvin	A GENEEN		R-C	
	495114	B. WING		09/22/2016	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF ARLING			STREET ADDRESS, CITY, STATE, ZIP CODE 1785 SOUTH HAYES STREET ARLINGTON, VA 22202		
ACCOUNT TEACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETED	

## F 314 Continued From page 25

information and assessed the resident as a moderate risk.

The RD wrote a dietary note on 09/01/16 at 6:11 p.m., which documented: "Visited with [name of Resident # 112] to discuss recommendations to support wound healing...protein bars available to him at all times and he was encouraged to eat at least one daily to support wound healing..."

The RD was interviewed on 09/21/16 at 10:15 a.m. regarding Resident # 112. The RD was asked how often are residents seen the RD stated that is based on their risk. The RD was made aware that Resident # 112 was assessed as a high risk on 07/10/16, five days after his readmission on 07/05/16. The RD was asked it an albumin had been obtained for Resident # 112. The RD stated that an albumin, is really not a useful determination of nutritional status, as it once was. The RD was asked, she would order something like an albumin. The RD stated, no and went on to say the physician would normally order that. The RD was asked if she collaborates with the resident's physician in regards to wound healing strategies. The RD stated, "Not really." No specific nutritional recommendations were found for Resident # 112 on the 07/10/16 nutritional assessment. The resident's CCP was reviewed and documented to monitor the resident's intake, liberalize diet, and to monitor for decreased appetite. No other nutritional interventions were found for Resident # 112.

On 09/21/16 at approximately 10:40 a.m., the ADON (assistant director of nursing) was interviewed and was asked how do you know who which residents are to receive weekly skin assessments. The ADON stated that on

F 314

FORM CMS-2567(Q2/99) Previous Versions Obsolete

Event IO: 0MV812

Facility ID: VA0186

It continuation sheet Page 26 of 44

T-855 P0028/0045 F-623

, , ,		
	PRINTED: 09/30/2016	
	FORM APPROVED	
	OLLO LIA BAAR MAAL	

		HIAND HUMAN SERVICES			FORMAPPROVED OMB NO. 0938-0391
STATEMEN!	TENTERS FOR MEDICARE & MEDICAID SERVICES  (ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED R-C
		495114	B. WING	· ·	09/22/2016
NAME OF	PROVIDER OR SUPPLIE	1) d 1) a man of the transfer	4.,,,,	STREET ADDRESS CITY, STATE, 2N	P CODE
REGEN	Y CARE OF ARLING	STON, LLC		1785 SOUTH HAYES STREET ARLINGTON, VA 22202	
(X4) ID PREFIX YAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST 66 PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAG	EX (EACH CORRECTIVE ACT)	ION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 314	Continued From p	page 26	F (	314	
	admission, MDS of enters it into the of that it doesn't mat skin problem or no assessment information	does their assessment and then omputer. The ADON stated ter if a resident had a current of upon admission, skin mation is put into the system by earts to be completed on each			
	assessments wer 112 from 07/12/16 stage III pressure buttocks. The AD	sked why, full body skin e not completed on Resident # 5 through 08/29/16, when the area was found on his ION stated that she would look k to this surveyor.			
	ADON stated, "Evaluated assessments" was	proximately 11:25 a.m. the ren though it [weekly skin sn't completed, we have a ssessment that was completed."			
	evaluation forms ( reviews and touch	ve weekly nursing assessment were reviewed. This form les on 12 different systems from der to skin. The following were			
	skin temperature, conditionNorma good/within norm; warm/dry/intact, n findings 1B. Abn assessment [this the resident's skin hoursNo new ar integrity [this area	m.) "skin ssment will include skin color, skin integrity, turgor and I findings indicate: skin color turgor is good; skin is o skin problems1A. Normal ormal findings from skin was blank] 1C. New changes to i integrity noted in the last 24 eas1D. New changes in skin was blank]" This form bes wound care and dressing,			

the entire area was blank, no preventative

DEPARTMENT OF HEALTH AND HUMAN SERVICES

703-979-8190

P0029/0045 F-623

PRINTED: 09/30/2016

FORM APPROVED OMB NO 0938-0391

- CERTERS FOR MEDICAL	KE & MEDICAID SERVICES				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X4) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
	495114	B. WING _		09/22/2016	
NAME OF PROVIDER OR SUPPLIE REGENCY CARE OF ARLIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1785 SOUTH HAYES STREET ARLINGTON, VA 22202		
PRESIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	DBE COMPLETION	

F 314 Continued From page 27

measures were marked, the entire area was blank.

08/21/16 (7:36 p.m.) "...skin. assessment-assessment will include skin color, skin temperature, skin integrity, turgor and condition...Normal findings indicate: skin color good/within norm; turger is good; skin is warm/dry/intact, no skin problems...1A. [area was blank-no information documented] 1B. Abnormal findings from skin assessment [this was blank] 1C. New changes to the resident's skin integrity noted in the last 24 hours...No new areas...1D. New changes in skin integrity [this area was blank).. " This form additionally describes wound care and dressing, the only information documented was, "treatment on right foot continues as ordered." No other information was documented in the wound care/dressing, preventative measures section.

08/27/16 (2:19 p.m.) "...skin as sessment-assessment will include skin color, skin temperature, skin integrity, turgor and condition...Normal findings indicate: skin color good/within norm; turger is good; skin is warm/dry/intact; no skin problems...1A. [area was blank-no information documented) 18. Abnormal findings from skin assessment (this was blank) 1C. New changes to the resident's skin integrity noted in the last 24 hours...No new areas...1D. New changes in skin integrity [this area was blank)..." This form additionally describes wound care and dressing, the only information documented was, "treatment on right foot continues as ordered" and "encourage frequent turning and repositioning." No other information was documented in the wound care/dressing, preventative measures section.

F 314

FORM CMS-2557(02-99) Previous Versions Obsolete

Event (0: 0MV&12

Facility ID: VA0186

If continuation sheet Page 28 of 44

# DEPARTMENT OF HEALTHAND HUMAN SERVICES

PRINTED: 09/30/2016 FORM APPROVED OMB NO. 0938-0391

and the second section of the sectio					
		n ti		(X3) DATE SURVEY COMPLETED	
		•		1 1	R-C
	495114	B. WING,		09	/22/2016
VIDER OR SUPPLIE	}		STREET ADCRESS, CITY, STATE, ZIP CODE	-	
CARE OF ARLING	STON, ELC	ŀ			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	IĎ PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(XŠ) COMPLETION DATE
	ORRECTION  OVIDER OR SUPPLIEF  CARE OF ARLING  SUMMARY ST  (EACH DEFICIENCE	ORRECTION IDENTIFICATION NUMBER:	DENTIFICATION NUMBER:  A. BUILDING  495114  B. WING  DIFFER OF ARLINGTON, ELC  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX	A BUILDING  495114  B. WING  DVIDER OR SUPPLIER  CARE OF ARLINGTON, ELC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR US OIL DENTIFYING INFORMATION)  REGULATORY OR US OIDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED TO THE APPLIANCE OF THE APPLIANCE	A. BUILDING  495114  B. WING  OSTRECT ADDRESS, CITY, STATE, ZIP CODE  1785 SOUTH HAYES STREET  ARLINGTON, LLC  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR US CIDENTIFYING INFORMATION)  TAG  CROSS.REFERENCED TO THE APPROPRIATE

#### F 314 Continued From page 28

F 314

08/28/16 (10:30 p.m.) "..skm assessment-assessment will include skin color, skin temperature, skin integrity, turger and condition...Normal findings indicate: skin colorgood/within norm; turgor is good; skin is warm/dry/intact, no skin problems...1A. Normal findings 1B. Abnormal findings from skinassessment [this was blank] 1C. New changes to the resident's skin integrity noted in the last 24 hours. No new areas...1D. New changes in skinintegrity (this area was blank)..." This form additionally describes wound care and dressing. the only information documented was, "treatable wounds present-treatment completed as progred." No other information was documented in the wound care/dressing, preventative measures section.

The ADON stated that the wound physician could be reached if the survey team would like to speak with him.

An interview was conducted with wound physician on 09/21/16 at 3:35 p.m., via telephone with the survey team. The physician was asked Resident # 112 and the stage III pressure area that found. The physician stated that screening is done by nursing staff and bring any issue up to initiate treatment early, when they brought it to me it was a stage III. The physician stated that he was not sure who is doing the assessment and what they are reporting, which nurse. The physician was told about the lack of assessments and was made aware that a CNA documented redness on 08/18/16, but did not report it. The physician stated that a stage III could develop in 11 days. The physician stated that he was not sure of the facility's policy on skin assessments.

DEPART MENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/30/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILOIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495114	B. WING _			R-C 09/22/2016	
	VIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, 2IP CO 1785 SOUTH HAYES STREET ARLINGTON, VA 22202			
(X4) IÚ PŘEFIX TAG	(ÉACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(×5) COMPLETION OATE	

#### F 314 Continued From page 29

F 314

The administrator, DON (director of nursing) and ADON were made aware of concerns regarding Resident # 112 being found with a stage III and the lack of weekly skin assessments, in a meeting with the survey team on 09/21/16 at 3:50 p.m. The facility policy and procedure was requested on skin assessment completion.

The "Skin Checks" policy and procedure was presented and reviewed on 09/22/16. The policy documented: "...The nursing facility is committed to identifying and implementing timely treatments to all skin conditions...Comprehensive skin checks will conducted on all residents at admission, readmission, weekly and as needed...abnormalities will be identified and documented in the clinical chart.. CNAs will monitor for skin changes throughout their shift...area of abnormality found by the aide will be reported to a licensed nurse who will assess...additional preventative interventions to prevent recurrence...detailed documentation...chart will be undated as needed to reflect the stalus of the skin condition. ADON or designee will review the documentation and monitor..."

On 09/22/16 the DON presented an email from the wound physician, which documented: "...To whom at [sic] may concern, ...several weeks ago he was noted to have a small buttock pressure injury about 1 cm [centimeter]...Pl [pressure injury] is not clear however it is within the realm of possibility for it to develop at any time given surrounding environment. Pl develop in short duration from 1 to 4 hours as is well noted in the literature..."

703-979-8190

T-855 P0032/0045 F-623
PRINTED: 09/30/2016
FORMAPPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (XB) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER A. BUILDING \_\_\_ AND PLAN OF CORRECTION R-C 09/22/2016 A WING 495114 STREET ADDRESS, CITY, STATE, 2IP CODE NAME OF PROVIDER OR SUPPLIER 1785 SOUTH HAYES STREET REGENCY CARE OF ARLINGTON, LLC ARLINGTON, VA 22202 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID FREFIX COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE (XAHD) (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR USC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG P 314 F 314 Continued From page 30 On 09/22/16 at approximately 8:30 a.m., the "literature" the physician was referring to was requested by the survey leam. At approximately 9:50 a.m., the information was presented and reviewed. The "How much time does it take to get a pressure Ulcer? Integrated evidence from human, animal, and in vitro studies" Volume 54-Issue 10 -October, 2008 was reviewed and documented: "...Surprisingly, information regarding the timeframe for pressure onset, particularly for deep tissue injury onset, is scant..." The provided "literature" did not indicate or specify any information regarding a stage III pressure ulcer No further information or documentation was presented to evidence that Resident # 112 had weekly full body skin assessments completed for F-Tag 323 the prevention of a stage III pressure ulcer; no further information and/or documentation was Criterion # 1- Correction presented to evidence that Resident # 112's stage III pressure ulcer was unavoidable Smoking assessment was (F 323) (F 323) 483.25(h) FREE OF ACCIDENT completed for resident # 103 on SS=D HAZARDS/SUPERVISION/DEVICES 9/20/16. The facility must ensure that the resident Criterion # 2-Other Potential environment remains as free of accident hazards as is possible; and each resident receives A 100% audit will be done by adequate supervision and assistance devices to Social Services to ensure prevent accidents. current residents who smoke have an updated smoking assessment and accurate information is in the medical This REQUIREMENT is not met as evidenced

Based on resident interview, staff interview.

by:

record

### DEPARTMENT OF HEALTH AND HUMAN SERVICES EDICARE & MEDICAID SERVICES

CENTERS FOR WE STATEMENT OF DEFICIEN AND PLAN OF CORRECTION	CIES (X1) PROVIDER/SUPPLIER/CLIA IN IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		X3) DATE SURVEY COMPLETED  R-C
	495114	8. WING _		09/22/2016
NAME OF PROVIDER OF REGENCY CARE OF			STREET ADDRESS, CITY, STATE, ZIP CODE 1785 SOUTH HAVES STREET ARLINGTON, VA 22202	
(E40H	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL NTCRY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION

## (F 323) Continued From page 31

clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to assess one of 18 residents in the survey sample for smoking safety (Resident # 103).

The facility staff failed to assess Resident # 103 to ensure the resident was safe to smoke

#### Findings include:

Resident # 103 was admitted to the facility on 07/20/16, with the most-current readmission on 08/19/16. Diagnoses for Resident #103 included, but were not limited to: anemia, HTN (high blood pressure), pneumonia, asthma, cellulitis of the right lower extremity and right knee replacement, and osteoarthritis.

The most current MDS (minimum data set) with CAAS (care area assessment summary) was a 14 day admission assessment, dated 09/02/16. This MDS assessed the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills The resident was also assessed as requiring extensive assistance for transfers and ambulation.

A complaint investigation was conducted on 09/19/16 through 09/22/16. An allegation of smoking safety was an allegation within the complaint.

On 09/20/16 at 8:50 a.m., Resident # 103 was interviewed in his room, with his wife present. The resident had a partial pack of cigarettes on night stand beside his bed. The resident was asked about the cigarettes. The resident stated {F 323}

## Criterion #3 System Change

Licensed Nursing staff and Social Services staff will be reeducated on the importance of completing and/or revising the comprehensive care plan and smoking assessment. Any new residents who are admitted will be advised that the facility is a smoke free center per facility policy. The care plan will be updated as the resident's ability to smoke changes. On a monthly basis during the QA committee a list of current residents who smoke will be submitted by Social Services/designee.

# Criterion # 4-Monitoring

Social Services will monitor the residents who smoke to ensure all smoking assessments and care plans remain up to date. On a monthly basis Social Services will submit a listing of all residents that smoke to the OA committee for review. Social Services will audit 15% of residents that smoke to ensure the policy is followed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/30/2016 FORM APPROVED

CENTER	REFORMEDICARI	8 MEDICAID SERVICES		OMB NO. 0938		
STATEMEN!	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X3) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DAT COM	E SURVEY PLETED
		495114	8. WING		09/	-C 22/2016
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, 21	P CODE	The state of the s
REGENC	Y CARE OF ARLING	TON, ELC		1785 SOUTH HAYES STREET ARLINGTON, VA 22202		
(X4) ID PREFIX TAG	(EACH DÉFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
(F 323)	quit. The resident to smoke alone. The sake me where I am see me coming do going to smoke an resident stated, "Swith me most of the stated that there are smoke breaks are, if he ever went out resident stated that went out last night he "got caught", the little later than usual caught him.  Resident # 103's con No smoking assess the clinical record.  The resident's currinformation was for regarding smoking.  The resident's currinformation was for regarding smoking.  On 09/20/16 at 10: nursing) was asked policy.	r although he was trying to was asked if he goes outside he resident stated that staff will in going most of the time if they will the half and I tell them I'm dithey will go with me. The he (pointing to his wife) goes eitime." The resident further respecific times of when. The resident was then asked side alone to smoke. The times a matter of fact he had (09/19/16) by myself and that e resident voiced that it was a a and his favorite nurse had dinical record was reviewed, sment could be located within ent CCP was reviewed. No und on the resident's CCP ent/active POS (physician's eviewed and documented, in supervised field trips" No und on the POS regarding	{F 32	Criterion #5- The dutifully alleges of these tasks on or by 10/11/16. It is also note that the facility and maintain company the regulatory required.	ompliance of operation of the control of the contro	
*		was presented and reviewed. nted, "Policy and Procedure				

Topic: Smoking...Date initiated: 09/01/16...The facility promotes a safe, healthy and smoke free

10-05-16 16:56 FROM- Regency Care of Arli -703-979-8190 T-855 -P0035/0045 F-623 MKINTED, DBIODIZOT FORMAPPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIÉR/CLIA COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING \_ R-C 09/22/2016 8. WING 495114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1785 SOUTH HAYES STREET ARLINGTON, VA 22202 REGENCY CARE OF ARLINGTON, LLC PROVIDER'S PLAN OF CORRECTION (X5) CONPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4)(D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PEEFIX REGULATORY OR LIST IDENTIFYING INFORMATION) TAG DEFICIENCY) {F 323} (F 323) Continued From page 33 environment...Residents who resided at the facility prior to August 11, 2016, and who smoked will continue to have the right to smoke at the facility following safe smoking protocols...1. Prior to admission and during the admission process, the resident and/or responsible party will be advised in writing of the facility smoking policy. 2. The resident's desire to smoke and any needed assistance/supervision will be addressed in the resident's comprehensive plan of care...the fácility does not allow for residents to keep any flammable smoking materials in their room...4. (dentified resident (sic) who wishes (sic) to utilize the designated outdoor smoking areas will be assessed by the nursing department using the Safe Smoking Assessment..." On 09/20/16 at approximately 4:00 p.m., in a meeting with the survey team, the administrator, DON (director of nursing) and the ADON (assistant director of nursing) were asked, where the smoking assessments were located for residents. The DON pointed to the computer and stated that they were in the computer. The above staff were informed that a smoking assessment could not be located for Resident # 103.

On 09/21/16 at approximately 3:50 p.m., the DON, administrator and ADON were again made aware of concerns regarding the above information. The DON stated, that the resident did not tell them (facility staff) that he smoked and further stated that a smoking assessment had been completed. A smoking assessment for Resident # 103 was presented and reviewed. The smoking assessment was dated 09/20/16 and timed 5:04 p.m. The DON was asked, if this smoking assessment was completed after this

surveyor brought the information to the facility's

Event ID: 0MV812

Facility to: VAC186

EPARIMI	ENT OF HEALTH	AND HUMAN SERVICES				FORM APPROVED OMB NO. 0938-0391
ENTERS	FOR MEDICARE DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE SURVEY COMPLETED R-C
		495114	B. WING			09/22/2016
ME OF PRC	DVIDER OR SUPPLIER			<b>178</b> 5	ET ADORESS, CITY, STATE, ZIP CODE SOUTH HAYES STREET	
EGENCY	CARE OF ARLING	STON, LLC		ARL	INGTON, VA 22202	
(X4) 10 PREFIX 1AG	1 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	iD PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OLD BE COM ST.
				323}		
F 323) C	Continued From p	page 34 0/16 at 4:00 p.m., in a meeting	, -	,		
V	vith the survey le	am. The DON stated, 165.				
۶ ۵ ۶ ۲	oresented prior to )9/22/16 at 10:45 † 103 was assess es.dent was safe	ation or documentation was the exit conference on a.m. to evidence that Resider sed by facility staff to ensure the PROCURE, E/SERVE - SANITARY	e	371		
-	The facility must:				F-Tag 371	
(	<ol> <li>Produce food to considered satisf</li> </ol>	from sources approved or actory by Federal, State or loc	al		Criterion # 1-Co	rrection
i	authorities, and (2) Store, prepart under sanitary co	e, distribute and serve food anditions			Hairnets and glovavailable and issu immediately correct on 9/20/16.	ies were
	This REQUIREM	MENT is not met as evidenced				
	facility document	ent interview, staff interview an f review, the facility staff failed ribute food in a sanitary manne units (Unit 2).	10			
	The facility staff checking food te	failed to wear a hair net, while emperatures on Unit 2.				
	on 09/19/16 at 4	nt interview with Resident # 117 (:00 p.m., the resident stated the facility are cold at times.	? nat			
	THE THEOLOGIC	-				

T-855 P0036/0045 F-623

10-05-16 16:56 FROM- Regency Care of Arli 703-979-8190

OMB NO.0938-0391

#### DEPARTMENT OF HEALTHAND HUMAN SERVICES SPINICHO AGE & MEDICAID SERVICES

CENTERS STATEMENT OF AND PLAN OF G	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI	PLE CONSTRUCTION		
		495114	B. WING		09	R-C <u>}/22/2016</u>
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2IP CODE 1785 SOUTH HAYES STREET ARLINGTON, VA 22202		
(%4) O PREFIX YAG	JEACH DEPICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFÉRENCED TO THE APPF DEFICIENCY)	ULDBE	COMPLETION DATE

### F 371 Continued From page 35

was observed. A steam table was set up with breakfast food items consisting of, but not limited to eggs, sausage, bread, patmeal and grits.

The DA (dietary aide) # 1, had a hairnet on, as well as gloves. The DA was asked if temperatures are checked off of the steam table. The DA stated, yes and went on to say that the temperatures are checked downstairs first, then the food is brought up and then rechecked on the steam tables. The DA was asked to see the temperatures. The DA stated, "They are downstairs." The DA was questioned about the previous statement that food temperatures are checked downstairs and then upstairs. The DA then stated that she did not do them this morning because her thermometer was broken and the DM (dietary manager) was bringing her one.

At approximately 8:35 a m., this surveyor left the dining room area and proceeded down the hall and met the DM in the hall. The DM was carrying coffee cups and was asked if food temperatures are checked downstairs and then upstairs. The DM stated, "Yes.". The DM was then asked if she (the DM) had heard anything about a broken thermometer on Unit 2 (steam table) The DM stated, "No." The DM was asked if she could obtain a thermometer to check temperatures on the steam table on the Unit 2 dining room. The DM stated, "Yes." The DM dropped off the cups to the dining room and proceeded downstairs to obtain a thermometer.

At approximately 8.40 a.m., the DM returned and began checking temperatures on the food items on the steam table. The DM did not don (put on) a hairnet prior to being in food serving area and did not don gloves. The DM was asked if she

#### Criterion # 2-Other Potential F 371

Meal observation audits have been done, no other unit/residents were identified as being impacted.

# Criterion #3-System Change

Dietary staff will be re-educated on the importance of donning gloves and hairnets at all times when on duty.

# Criterion # 4-Monitoring

A 100% audit will be done during meal services by Dietician/Designee to ensure haimets and gloves are being worn by dietary staff while on duty.

Each meal x 1 week, 2 meals a day x one week, then 1 meal a day x 2 week audits will be conducted by Dietician and/or designee to ensure hairness and gloves are being worn by dietary staff while on duty.

Variances will be corrected and investigated. A summary of the weekly audits will be submitted to the QA Committee for additional oversight and recommendation.

FCRM CMS-2567(02-99) Previous Versions Obsolete

Event ID:0MV812

Facility ID: VA0186

If continuation sheet may= 36 of 44

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

495114

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

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

A. BUILDING R-C

B. WING 9938-0391

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY

(X3) DATE SURVEY

(X4) DATE SURVEY

(X9) DATE SURVEY

(

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

REGENCY CARE OF ARLINGTON, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

1785 SOUTH HAYES STREET ARLINGTON, VA 22202

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE

F 371 Continued From page 36

was suppose to have a hairnet and gloves on. The DM stated, "Yes Ma'am." The food temperatures were well above normal.

The DM was then asked for a policy regarding hair restraints.

A policy was later presented and reviewed on "Personnel Adherence to Sanitary Procedures", which documented: "...food services personnel shall follow appropriate sanitary procedures...hairnets or approved hats, covering all hair, must be worn at all times while on duty..."

The administrator, DON (director of nursing) and the ADON (assistant director of nursing) were made aware in a meeting with the survey team on 09/20/16 at approximately 4:00 p.m.

No further information or documentation was presented prior to the exit conference on 09/22/16 at 10:45 a.m.

F 425 483.60(a),(b) PHARMACEUTICAL SVC -SS=D ACCURATE PROCEDURES, RPH

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident

F 371

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

F 425

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0MV812

Facility ID: VA0186

if continuation sheet Page 37 of 44

T-855 P0039/0045 F-623 PRINTED 09/30/2016 FORMAPPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICENCIES (X3) PROVIDER/SUPPLIER/CLIA

DENTIFICATION NUMBER:

495114

(X2) MULTIPLE CONSTRUCTION A. BUILDING \_

(太3) DATE SURVEY COMPLETED

R-C

09/22/2016

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

REGENCY CARE OF ARLINGTON, LLC

STREET ADDRESS, CITY, STATE, 2IP CODE 1785 SOUTH HAYES STREET

ARLINGTON, VA 22202

(X4)10 PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)

10 PREFIX YAG

B, WING

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 425 Continued From page 37

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced

Based on staff interview, clinical record review and complaint investigation, the facility staff failed to ensure medications were available for administration for two of 18 residents in the survey sample.

- 1 Resident #115 missed doses of the medications Singulair and Spironolactone because they were not available from pharmacy.
- Resident #111 missed doses of the medication Aricept because it was not available.

The findings include:

1. Resident #115 missed a dose of the medication Singulair and missed two doses of the medication Spironolactone because the medications were not available for administration.

Resident #115 was admitted to the facility on 7/20/16 with diagnoses that included asthma, heart failure, high blood pressure and chronic kidney disease. The minimum data set (MDS) dated 8/17/16 assessed Resident #115 as cognitively intact.

Resident #115's clinical record documented a

F 425

F-Tag 425

## Criterion #1-Correction

Resident # 111 has not demonstrated any adverse outcome. Aricept is available. The physician has been notified of the Aricept that was not documented as being administered.

Resident # 115 has been discharged home and did not demonstrate any adverse outcome prior to discharge.

## Criterion # 2-Other Potential

A 100% audit will be done for current residents to ensure all residents have their medications availabie.

# Criterion #3-System Change

Licensed Nursing staff will be re-educated on the importance of ordering medication in a timely manner.

Licensed Nursing staff will be re-educated on the facility protocol when receiving new orders for medications that are not readily available.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: VA0186

If continuation sheet Page, 38 of 44

PRINTED: 09/30/2016
FORMAPPROVED
OMP NO 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATE WENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION R-C 09/22/2016 B. WING 495114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1785 SOUTH HAYES STREET ARLINGTON, VA 22202 REGENCY CARE OF ARLINGTON, LLC PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFD. CROSS-REFERENCED TO THE APPROPRIATE PRETIX TAG REGULATORY OR USC IDENTIFYING INFORMATION) DEFICIENCY) TAS

## F 425 Continued From page 38

physician's order dated 7/21/16 for the medication Singulair 10 mg (milligrams) to be administered at each bedtime for the treatment of asthma. The record also documented a physician's order dated 7/21/16 for the medication Spironolactone 100 mg to be administered each day for treatment of congestive heart failure.

Resident #115's medication administration record (MAR) for August 2016 documented the Singulair was not administered on 8/22/16. The MAR documented the Spironolactone was not administered on 8/27/16 and 8/28/16. A nursing note dated 8/22/16 concerning the missed dose of Singulair stated, "Pharmacy to deliver. Not given." Concerning the missed doses of Spironofactone, a note dated 8/27/16 stated, "Medication on order. Not administered." A note dated 8/28/16 stated, "Medication on order."

On 9/21/16 at 1:05 p.m. the director of nursing (DON) was interviewed about the lack of availability of Resident #115's medications. The DON stated nurses were supposed to re-order medications from the pharmacy prior to exhausting the supply. The DON stated nurses were able to re-order medications directly from the pharmacy using their computer system. Concerning Resident #115's missed Singulair and Spironolactone in August 2016, the DON stated re-ordering the medications "was not done timely."

These findings were reviewed with the administrator and director of nursing during a mieeting on 9/21/16 at 3:50 p.m.

This was a complaint deficiency.

# F 425

### Criterion # 4-Monitoring

2 times weekly and every week x 2 months, 3 current residents and 3 new admission/readmission orders will be audited by Unit Managers/designee to ensure availability of medication(s).

Variances will be investigated and corrected as appropriate. An analysis of the weekly audits will be provided to the QA Committee for additional oversight and recommendation.

> Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM	1 APPROVEĎ 1 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SE		8 MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION BUILDING		(x3) DATE SURVEY COMPLETED	
		495114	8 MING			/22/2016	
and the second second	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C	ODE		
				1785 SOUTH HAYES STREET			
REGENC	Y CARE OF ARLING	STON, LLC		ARLINGTON, VA 22202			
(X4) ID PREFIX TAC	マスクコ へらむけんほだ	ATEMENT OF DEFICIENCIES IN MUST BE PRECEDED 8Y FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	COMPLETION DATE	
	Continued From p	age 39	F	425			
	medication, Aricep	ff failed to ensure the ot (donepezil) (used in the usion related to dementia) was nistration for Resident # 111.					
	Findings include						
	originally in 2014, readmission on 09 Resident # 111 ind mestatic cancer.	as admitted to the facility with the most recent a/03/16. Diagnoses for cluded, but were not limited to: seizure disorder, anxiety a (inability to sleep) and					
	significant change This MDS assess score of "9", indic impairment in dail resident also trioc	MDS (minimum data set) was a e assessment dated 09/02/16, led the resident with a cognitive ating the resident had moderate by decision making skills. The gered for cognition in the CAAS sment summary) section of this	B				
	During a complain through 09/22/16 records were revi	nt investigation on 09/19/16 . Resident # 111's clinical ewed.					
	Resident # 111's set) was reviewed Ancept 5 milligran	current POS (physician's order d and documented an order for, ms every night.	) ·				
	records) were rev	ARs (medication administration viewed for September 2016. Or and 18th it was documented with	()				

an "O", indicating "Other/See Progress Notes."

DEPARTMENT	OF HEALTH	MAMUH DNA	SERVICES
717 W. V.	MEDICADE	e MEDICAID	SERVICES

OMB NO. 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAIL (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER A. BUILDING \_ AND PLAN OF CORRECTION R-C 09/22/2016 B. WING . 495114 STREET ADDRESS, CITY, STATE ZIP COCE NAME OF PROVIDER OR SUPPLIER 1785 SOUTH HAYES STREET REGENCY CARE OF ARLINGTON, LLC ARLINGTON, VA 22202 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES ID) DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL 754110 PRESIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG

# F 425 Continued From page 40

The resident's progress notes were then reviewed for September 2016. The progress note dated 09/17/16 and timed 9:49 p.m. documented, "Donepezi(...5 mg tablet...Not available..." A progress note dated 09/18/16 and timed 8:24 p.m. documented, "Donepezil...5 mg tablet...Not available..."

The resident's current CCP (comprehensive care plan) documented, '. The resident has impaired cognitive function/dementia or impaired thought processess...related to frontal lobe demential ..communicate with the resident...cue, reorient and supervise as needed...administer medications as ordered..."

The DON (director of nursing), administrator, ADON (assistant director of nursing), and the corporate nurse were made aware in a meeting with the survey team on 09/21/16 at 3:50 p.m.

No further information or documentation was presented prior to the exit conference on 09/22/16 at 10:45 a.m., to evidence the facility had the medication Aricept available for administration, as ordered by the physician.

(F 431) 483 60(b), (d), (e) DRUG RECORDS, SS=D LABEL/STORE DRUGS & BIOLOGICALS

> The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate recordilation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled

F 425

{F 431}

FORM CMS 2587(02-99) Previous Versions Obsolete

Event ID: 0Mv812

Facility ID; VA0186

Hicontinuation sheet Page 41 of 44

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview and facility document review, the facility staff failed to discard expired medications on one of 3 nursing units. An expired bottle of Lorazepam oral concentrate and three expired vials of injectable Lorazepam were available for use in the medication storage refrigerator on unit #3.

The findings include:

On 9/21/16 at 2:00 p.m. accompanied by licensed practical nurse (LPN) #6 the medication storage

Licensed nursing staff will be re-educated on the facility policy for destroying and returning expired medications and on destruction of narcotics. The DON/ADON will destroy narcotics twice weekly.

PRINTED: 09/30/2016 FORM APPROVED

	F ORM APPROVED
DEPARTMENT OF HEALTH AND HUMAN SERVICES	OMB NO. 0 <u>938-0391</u>
CENTERS FOR MEDICARE & MEDICAID SERVICES	/Y 3\ DATE SHEVIEY

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	ES (X1) PROVIDER/SUPPLIER/CLIA	(XZ) MULTIPLE CONSTRUCTION  A, BUILDING		COMPLETED R-C
	495114	B. WING		09/22/2016
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF ARLINGTON, LLC			STREET AODRESS, CITY, STATE, 2IP CODE 1785 SOUTH HAYES STREET ARLINGTON, VA 22202	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PRÉFIX (EACH DEFICIENCY MUSY BE PRECEDED BY FULL  PRÉFIX (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMMERCION

# (F 431) Continued From page 42

refrigerator on unit #3 was inspected. Stored in the refrigerator and available for use was an unopened 30 milliliter bottle of Lorazepam concentrate (2 milligrams/milliliter) labeled by the manufacturer with an expiration date of 7/2016. Also in the refrigerator were three 1 (one) milliliter vials of injectable Lorazepam (2 milligrams/milliliter) labeled by the manufacturer with an expiration date of 8/2016.

On 9/21/16 at 2.00 p.m. LPN #6 was interviewed about the expired Lorazepam stored in the unit's refrigerator. LPN #6 stated the expired Lorazepam was prescribed for current residents on the unit. LPN #6 stated the expired medications should have been sent back to the pharmacy. LPN #6 stated pharmacy usually picked up out of date medications.

On 9/21/16 at 2:05 p.m. the director of nursing (DON) was interviewed. The DON stated the unit managers were supposed to check medication storage for expired medications. The DON stated she and the assistant director of nursing (ADON) were responsible for disposing of any narcotics.

The facility's policy titled Medication Disposal Policy (dated 9/13/16) stated, "Facility will obtain order to discontinue medications that are no tonger in use by the resident... DON/ADON or Designee will retrieve discontinued/expired narcotics from the assigned nurse as soon as it is known that a resident has discharged or within 72 hours of discharge...Medications that are unable to be returned to the pharmacy should be disposed of according to applicable laws and guidelines... Unused non-narcotic prescriptions and over the counter (OTC) medications that do not meet criteria for return to the Pharmacy shall

(F 431)

### Criterion #4- Monitoring

Unit Managers and/or designee will check refrigerators three times weekly x 2 months on each unit to ensure medications have not expired. Variances will be corrected and investigated. Findings from audits will be given to DON/ADON for trending patterns. A summary of the weekly audits will be submitted to the QA Committee for additional oversight, recommendation and the need for further monitoring.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

T-855 P0045/0045 F-623 0-05-16 16:57 FROM- Regency Care of Arli 703-979-8190 PRINTED: 09/30/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED QMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_ R-C 09/22/2016 B. WING 495114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1785 SOUTH HAYES STREET REGENCY CARE OF ARLINGTON, LLC ARLINGTON, VA 22202 PROVIDER'S PLAN OF CORRECTION (X5; COMPLETIÓN DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ıĎ. (EACH CORRECTIVE ACTION SHOULD BE (34)10 PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY) {F 431} (F. 431) Continued From page 43 be disposed of by the Unit Manager." These findings were reviewed with the administrator and director of nursing during a meeting on 9/21/16 at 3:50 p.m.