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

PRINTED: 10/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495114	A. BUILDING _____ B. WING _____	R 10/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF ARLINGTON, LLC	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)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid second revisit to the first revisit conducted 9/19/16 through 9/22/16 and a standard survey conducted on 8/2/16 through 8/4/16 was conducted 10/18/16 through 10/19/16. Corrections are required for compliance with the following Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. The census in this 240 bed facility was 142 at the time of the survey. The survey sample consisted of fourteen current resident reviews (Residents #201 through #214).	{F 000}	This plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement of them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements.	
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for one of 14 residents in the survey sample (Resident # 211) to follow physician's orders for the administration of medication. Resident # 211 was administered an antihypertensive medication that was to be held for low blood pressure. The findings were:	{F 309}	**F-Tag 309 Criterion # 1-Correction** Resident # 211 has not demonstrated adverse outcome from blood pressure medication being administered outside of parameter. Physician was notified of resident receiving blood pressure medication outside of parameter. **Criterion#-2-Other Potentials** A 100% audit of current residents receiving blood pressure medications was conducted on 10/26/16 to ensure other residents were not affected.	

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OCT 26 2016
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

10/26/16

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

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Resident # 211 in the survey sample, a 54 year-old female, was admitted to the facility on 11/11/09 and most recently readmitted on 1/22/16 with diagnoses that included end stage renal disease, diabetes mellitus, arteriosclerotic heart disease, hypertension, hyperlipidemia, history of a below the knee amputation, and seizures. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 7/28/16, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Resident # 211 had the following physician's medication order, dated 7/2/16:

Metoprolol Tartrate Tablet 25 mg (milligrams). Give 0.5 (1/2) tablet orally every 12 hours every Sun (Sunday), Tue (Tuesday), Thu (Thursday), Sat (Saturday) related to essential (primary) hypertension. 1/2 tab (12.5 mg) (Hold for SBP [Systolic Blood Pressure] less than 110.)

(NOTE: Systolic blood pressure is a measure of the highest arterial blood pressure by which blood is forced onward from the left ventricle and the blood circulation is kept up. Ref. Langenscheidt's Medical Dictionary, Copyright 2002, page 684.)

(NOTE: Metoprolol is an antihypertensive used to treat mild to moderate hypertension. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 780.)

Review of the Electronic Medication Administration Record (EMAR) for the month of October 2016 revealed that on 10/15/16 (a

Criterion #-3-System Change

Nursing staff will be re-educated on the importance of following physician's orders and parameters for blood pressure medications.

Criterion #-4 Monitoring

2 times per week for 4 weeks, weekly x 4 weeks and then randomly x 4 weeks 4 residents' blood pressure medications on each unit will be audited by unit managers and or designee to validate that orders for blood pressure medications are being administered per physician's order. Findings will be given to DON/ADON for tracking of patterns. 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 10/28/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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Saturday), Resident # 211 received one dose of Metoprolol at approximately 9:00 p.m. Resident # 211's blood pressure at the time of administration was noted on the EMAR as 97/68, with 97 being the systolic pressure.

At 10:30 a.m. on 10/19/16, the surveyor and the Director of Nursing (DON) reviewed the resident's EMAR for the month of October 2016. After reviewing the Metoprolol administration entry for the 9:00 p.m. dose on 10/15/16, the DON stated that "...the Metoprolol should not have been given."

{F 309}

{F 312} SS=D 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, resident interview, and clinical record review, the facility staff failed to provide nail care for one of 14 residents, Resident #201.

Facility staff did not trim Resident #201's toe nails. Resident #201 stopped this surveyor during initial tour of the facility and asked if she could have her toe nails cut. She stated they were long and they hurt.

Findings were:

{F 312}

F Tag-312 Criterion #1 Correction

Resident # 201 toe nails were clipped and filed on 10/18/2016.

Criterion #2-Other Potentials

A 100% audit was conducted on current residents' toe nails to ensure other residents were not affected.

Criterion # 3 System Change

Podiatrist will in house every two weeks and as needed. Nursing staff will be re-educated on the importance of ensuring residents' toe nails are trimmed and/or file routinely and as needed.

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Resident #201 was admitted to the facility on 08/06/2016. Her diagnoses included but were not limited to: Hypertension, Type II Diabetes Mellitus, Atrial fibrillation and systolic congestive heart failure.

The most recent MDS (minimum data set) was a significant change assessment with a reference date of 10/07/2016. Resident #201 was assessed as having a cognitive summary score of "13", indicating she was cognitively intact.

Initial tour of the facility was conducted on 10/18/2016 beginning at 8:30 a.m. As this surveyor was leaving the fourth floor of the facility at approximately 9:15 a.m., Resident #201, who was sitting in her wheelchair at the nurse's station, stopped this surveyor and stated, "Please cut my toe nails. They are too long. Please."

This surveyor left Resident #201 and found the unit manager RN (registered nurse) #1 and asked him to speak with the resident. Resident #201 repeated her request to the unit manager. He stated, "The podiatrist is coming on Friday...you will have your toe nails cut then." The resident stated, "No, today. Please cut my toe nails, they are too long. They hurt." The unit manager again stated, "The podiatrist is coming on Friday." This surveyor asked the unit manager if this surveyor could visualize Resident #201's feet.

The unit manager took Resident #201 to her room and removed her socks. The toe nails were painted silver. The color did not extend to the cuticle of her toe nails indicating the nails had grown out since they had last been polished. The great toe of the right foot was short, yellowed and appeared thick. The great toe nail was not

Criterion # 4 Monitoring

Weekly x 4 weeks, bi-weekly x 8 weeks and then randomly x 4 weeks 4 residents' toe nails on each unit will be checked by unit managers and or designee to ensure toe nails are kept trimmed and findings will be given to DON/ADON for tracking of patterns. 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 10/28/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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polished. The second toe of her right foot rested on and overlapped the great toe. The nails on her right foot were long. All of the toe nails on her left foot had been painted. Three of the four nails were long.

Resident #201 stated, "Please cut them...I don't care about the color." The unit manager stated, "The podiatrist will be here Friday to cut them...the podiatrist can do it without harm to you." Resident #201 stated, "No, please, today." Resident #201 was asked if she was in pain. She stated, "Yes, they hurt...please cut them today."

The unit manager sent another staff member from the room to get nail clippers. He then cut the toe nails on Resident #201's feet. When he looked at one of the toes on her left foot he stated, "I am not going to cut this one, it is ingrown. The podiatrist will look at it." When he finished cutting the toe nails, Resident #201 was asked if that felt better. She stated, "Yes, it is better." She was asked how long it had been since she had her toe nails trimmed. She stated "Seven months."

The unit manager was asked how often the podiatrist came to the facility. He stated, "Every two week to once a month."

Review of the electronic clinical record was conducted. The POS (physician order sheet) contained the following order: "Medical Foot Care to be provided as indicated." The order was written 08/06/2016. The progress note section was reviewed. The following notes written 10/18/2016 were present: "Resident c/o [complained of] foot pain, level 3/10, medicated with Tylenol 650 mg [milligrams] at 9:00 a.m. with

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good results..." "Resident medicated with Tylenol 650 mg before nail trimming. Tylenol was effective toe nail trimmed without incident. md [sic] [medical doctor] was in building and made aware."

The care plan was reviewed. Interventions for the problem: "Resident had diabetes mellitus", included but were not limited to: "Educate resident/family/caregiver:...that nails should always be cut straight across, never cut corners. File rough edges with emery board" and "Inspect feet daily for open areas, sores, pressure area, blisters, edema or redness"

On 10/18/2016 at 2:50 p.m., LPN (licensed practical nurse) #1 was interviewed regarding the progress notes written on 10/18/2016 regarding Resident #201's feet. He stated, "She complained of foot pain...she said her nails were long...she is on the podiatrist list for Friday."

At 2:55 p.m., the unit manager stated, "The podiatrist was here but there was a long list and not everyone was seen...that is why the podiatrist is coming back on Friday." The unit manager showed this surveyor the podiatrist list for the unit. Resident #201 was not on the list for September but was on the list for October. He was asked when the podiatrist had last been at the facility. He stated, "I don't know...you saw me cut them...anyone could have done that, it took less than ten minutes...the CNA's [Certified nursing assistants] look at the nails when they do the baths."

A copy of the podiatry consult lists from the unit were requested and received. The top of the pages read: Podiatry Consults Month: _____ The

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blank was filled in with September 2016 and October 2016. Residents were listed by room number, name, reason and date seen. The date seen was not filled in on either the September or the October list. The DON presented a fax cover sheet addressed to the podiatrist that was sent on 10/07/2016. According to the DON the podiatrist had been at the facility on 10/10/2016 but Resident #201 was not seen on that visit due to the number of residents who needed podiatry services.

At 3:30 p.m. the DON (director of nursing) came to the conference room with the unit manager to speak with this surveyor. She stated, "We did a skin sweep on 10/4 and 10/7, we did not identify any issues. She is on the list for the podiatrist." The DON continued, "I was on the floor this morning and she told me about her feet...I looked at them and we got an order for Tylenol...I was going to go back up there but then you showed up..not all of them were long."

During a meeting with the DON and the administrator on 10/18/2016 at approximately 4:30 p.m. nail care was discussed. The DON was asked where nail care was documented. She stated "We don't really document nail care it is part of the daily routine."

No further information was obtained prior to the exit conference on 10/19/2016.