STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495114	A. BUILDING _____ B. WING _____	C 05/17/2017

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 Abbreviated (complaint) Survey was conducted 05/16/17 through 05/17/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four complaints were investigated during the survey. The census in this 240, certified bed facility was 128 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Resident #'s 1, 2, and 3) and 2 closed record reviews (Resident #'s 4 and 5).	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of	F 225		6/5/17

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

Electronically Signed | 06/05/2017

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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actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

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F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility staff failed to conduct a complete and thorough investigation for one of 5 residents in the survey sample, Resident # 5. Resident # 5 had a significant change in condition on 04/26/17, the resident was sent to the hospital and later expired. According to a facility reported incident dated 04/26/17, Resident # 5 had allegedly purchased medication that was ordered online and the facility was in the process of attempting to determine what the medication was. The facility staff failed to conduct a complete and thorough investigation regarding this incident. Findings include: Resident # 5 was admitted to the facility originally on 09/09/16, with the most current readmission on 11/18/17. Diagnoses for Resident # 5 included, but are not limited to MS (multiple sclerosis), history of UTI's (urinary tract infections), neuralgia, neuritis, slurred speech, muscle weakness, high blood pressure, and chronic pain. Resident # 5's most current MDS (Minimum Data Set) dated 03/28/17 assessed the resident as having a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as requiring extensive assistance from at least two staff members for most all ADL's (activities of daily living).	F 225	F Tag 483.12 Criterion #1: Audited closed chart and documentation from George Washington University Hospital Emergency Room Record and written statements obtained from staff related to occurrences on 4/26/2017 and added to investigation findings. Criterion #2: Any resident who has been involved in a facility reportable incident have the potential to have missing information that needs to be a part of the investigation. All facility reportable incidents in the last 30 days have been reviewed for compliance of the regulation with any missing information identified and attempts made to obtain. Criterion #3: The following system changes have been put into place to prevent future deficiencies and to remain in compliance with the regulations: 1. The facility administrator has in-serviced the IDT on conducting a thorough and complete investigation on all alleged incidents. 2. A QA tool has been developed to assist in auditing for compliance of this requirement. 3. The facility policy has been reviewed and updated and training provided to applicable staff	

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F 225	Continued From page 3 A complaint investigation was conducted on 05/15/17 through 05/17/17. An allegation within the complaint alleged that the facility failed to identify the medication ordered online by the resident. On 05/15/17 at approximately 1:30 p.m., the administrator and DON (director of nursing) were asked for the investigation for Resident # 5. At approximately 2:25 p.m., the DON presented a folder. The folder contained approximately 4 separate copies of the original FRI (facility reported incident) sent to the state agency, along with a follow up. The follow up was a brief, vague summary and did not include any details regarding the incident surrounding Resident # 5's change of condition or any information about medication being ordered online by the resident. Resident # 5's nursing notes were reviewed. A nursing note dated 04/26/17 and timed 2:30 p.m. documented (in summary) that at 2:30 p.m. (04/26/17) the resident propelled himself to his room, and requested for CNAs (certified nursing assistants) to put him to bed, he was not feeling well. The CNA called the nurse to the room, the resident was assessed by the nurse, while the resident was in bed. The nursing note documented that the resident was alert and oriented X 3 and able to make needs known at that time. Vital signs were taken and documented (within normal limits). The nurse asked the resident why he was so sleepy and the resident stated that he had taken some medication "called tavist, which he had ordered online." The resident did not tell the nurse the amount of medication taken. The nurse and the CNA then searched the room, "found 3 round	F 225	Criterion #4: The QA nurse will conduct weekly audits x8 weeks of the incidents to ensure all investigations are complete. The findings will be reviewed with the QA committee and determination will be made on the need for continued monitoring and frequency after the 8 weeks. Criterion #5: The facility Administrator is responsible for compliance of this requirement by or before 6/16/2017.	

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F 225	Continued From page 4	F 225		

yellow medication [sic] with label (Clamist) in resident drawer with an envelope addressed to the resident at facility." The nursing note then documented that the physician was notified and ordered for close monitoring of resident and morning labs. According to the nursing note at 3:15 p.m., the resident was in bed with noted grunting incoherent and lethargic. Oxygen was initiated, 911 was called and the resident was sent to the hospital via 911 at 3:50 p.m.

On 05/15/17 at 3:15 p.m., the facility's MD (medical director), DON and administrator were interviewed regarding the above information. The MD stated that a couple of days before (04/24/17) the resident had a fall out of his wheelchair and was seen by the MD. According to the MD the resident did not appear in distress after the fall and the resident verbalized that he was fine. Staff got the resident up off the floor and back into the wheelchair without any issues or concerns.

The MD stated that on 04/26/17 the resident's mentation had decreased and that the resident had mentioned taking an over the counter antihistamine and maybe he had taken 2 or 3. The MD stated we sent him out, we were searching his belongings to attempt to find out how many he had taken. The MD stated that after the resident was sent out, the staff searched his scooter and in the pouch/pocket there was a bottle of tincture of cannabis plant and that it was a 30 ml (milliliter) bottle and that approximately 10 ml was missing from the bottle, leaving a 20 ml in the bottle.

The DON, administrator and MD were all made aware that all of the above information should

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F 225	Continued From page 5	F 225		

have been part of their investigation. The DON was asked for a policy on reporting and investigation at this time. The DON stated that, "we" (the facility) did a time line in the nursing notes. The DON was made aware that there were no statements from the nurse and or CNAs that were caring for Resident # 5 and that critical details surrounding this incident were not provided in their investigation and/or follow up.

The facility staff provided a policy titled, "Investigative Analysis of Unusual Occurrences of Incidents" dated 03/01/17, documented, "...The facility is committed to a comprehensive investigation of all unusual occurrences or incidents...The form is to be completed within 5 calendar days of notification of unusual occurrence...does not replace your requirement to notify all required regulatory or enforcement entities...The form is to be completed entirely..." The policy included fill in the blank areas with specific details and a description page to document subjectively.

A policy titled, "Abuse, Neglect and Exploitation" documented, "...Neglect means failure of the facility, the employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress...interview the involved resident, if possible, and document all responses...if cognitively impaired, interview the resident several times to compare responses...interview the resident's family...or other individual's involved in the resident's life...interview witnesses separately...include roommates, resident's in adjoining rooms, staff members in the area, and visitors in the area. Obtain witness statements...All statements

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F 225	Continued From page 6 should be signed and dated by the person making the statement...document the entire investigation chronologically...Anyone in the facility can report....notify DON and administrator (document), initiate investigation immediately, Notify the attending physician, resident's family...obtain witness statements..." No further information and or documentation was provided to the exit conference on 05/171/17 at 9:00 a.m., to evidence that the facility conducted a complete, thorough and accurate investigation for Resident # 5.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F 226		6/5/17

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F 226	Continued From page 7 (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility staff failed to implement written policies and procedures for investigating abuse, neglect and/or exploitation for one of 5 residents in the survey sample, Resident # 5. The facility staff failed to follow written policies and procedures for the prevention of abuse, neglect and/or exploitation of Resident # 5, by not thoroughly investigating an unusual occurrence that had a potential for neglect. Findings include: Resident # 5 had a change in condition on 04/26/17 and was sent to the hospital, where the resident later expired. According to a facility reported incident dated 04/26/17, Resident # 5 had allegedly purchased medication that was ordered online and that the facility was in the process of ascertaining what the medication was. The facility staff failed to conduct a complete and thorough investigation regarding this incident.	F 226	F Tag 483.12 Criterion #1: Audited closed chart and documentation from George Washington University Hospital Emergency Room Record and written statements obtained from staff related to occurrences on 4/26/2017 and added to investigation findings. Criterion #2: Any resident who has been involved in a facility reportable incident have the potential to have missing information that needs to be a part of the investigation. All facility reportable incidents in the last 30 days have been reviewed for compliance of the regulation with any missing information identified and attempts made to obtain. Criterion #3: The following system changes have been put into place to prevent future deficiencies and to remain in compliance with the regulations: 1. The facility administrator has in-serviced the IDT on conducting a	

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F 226	Continued From page 8 Findings include: Resident # 5 was admitted to the facility originally on 09/09/16, with the most current readmission on 11/18/17. Diagnoses for Resident # 5 included, but are not limited to MS (multiple sclerosis), history of UTI's (urinary tract infections), neuralgia, neuritis, slurred speech, muscle weakness, high blood pressure, and chronic pain. Resident # 5's most current MDS (Minimum Data Set) dated 03/28/17 assessed the resident as having a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as requiring extensive assistance from at least two staff members for most all ADL's (activities of daily living). A complaint investigation was conducted on 05/15/17 through 05/17/17. An allegation within the complaint alleged that the facility failed to identify the medication ordered online by the resident. On 05/15/17 at approximately 1:30 p.m., the administrator and DON (director of nursing) were asked for the investigation for Resident # 5. At approximately 2:25 p.m., the DON presented a folder. The folder contained approximately 4 separate copies of the original FRI (facility reported incident) sent to the state agency, along with a follow up. The follow up was a brief, vague summary and did not include any details regarding the incident surrounding Resident # 5's change of condition or any information about medication being ordered online by the resident.	F 226	thorough and complete investigation on all alleged incidents. 2. A QA tool has been developed to assist in auditing for compliance of this requirement. 3. The facility policy has been reviewed and updated and training provided to applicable staff Criterion #4: The QA nurse will conduct weekly audits x8 weeks of the incidents to ensure all investigations are complete. The findings will be reviewed with the QA committee and determination will be made on the need for continued monitoring and frequency after the 8 weeks. Criterion #5: The facility Administrator is responsible for compliance of this requirement by or before 6/16/2017.	

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Resident # 5's nursing notes were reviewed. A nursing note dated 04/26/17 and timed 2:30 p.m. documented (in summary) that at 2:30 p.m. (04/26/17) the resident propelled himself to his room, and requested for CNAs (certified nursing assistants) to put him to bed, he was not feeling well. The CNA called the nurse to the room, the resident was assessed by the nurse, while the resident was in bed. The nursing note documented that the resident was alert and oriented X 3 and able to make needs known at that time. Vital signs were taken and documented (within normal limits). The nurse asked the resident why he was so sleepy and the resident stated that he had taken some medication "called tavist, which he had ordered online." The resident did not tell the nurse the amount of medication taken. The nurse and the CNA then searched the room, "found 3 round yellow medication [sic] with label (Clamist) in resident drawer with an envelope addressed to the resident at facility." The nursing note then documented that the physician was notified and ordered for close monitoring of resident and morning labs. According to the nursing note at 3:15 p.m., the resident was in bed with noted grunting incoherent and lethargic. Oxygen was initiated, 911 was called and the resident was sent to the hospital via 911 at 3:50 p.m.

On 05/15/17 at 3:15 p.m., the facility's MD (medical director), DON and administrator were interviewed regarding the above information. The MD stated that a couple of days before (04/24/17) the resident had a fall out of his wheelchair and was seen by the MD. According to the MD the resident did not appear in distress after the fall and the resident verbalized that he was fine.

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Staff got the resident up off the floor and back into the wheelchair without any issues or concerns.

The MD stated that on 04/26/17 the resident's mentation had decreased and that the resident had mentioned taking an over the counter antihistamine and maybe he had taken 2 or 3. The MD stated we sent him out, we were searching his belongings to attempt to find out how many he had taken. The MD stated that after the resident was sent out, the staff searched his scooter and in the pouch/pocket there was a bottle of tincture of cannabis plant and that it was a 30 ml (milliliter) bottle and that approximately 10 ml was missing from the bottle, leaving a 20 ml in the bottle.

The DON, administrator and MD were all made aware that all of the above information should have been part of their investigation. The DON was asked for a policy on reporting and investigation at this time. The DON stated that, "we" (the facility) did a time line in the nursing notes. The DON was made aware that there were no statements from the nurse and or CNAs that were caring for Resident # 5 and that critical details surrounding this incident were not provided in their investigation and/or follow up.

The facility staff provided a policy titled, "Investigative Analysis of Unusual Occurrences of Incidents" dated 03/01/17, documented, "...The facility is committed to a comprehensive investigation of all unusual occurrences or incidents...The form is to be completed within 5 calendar days of notification of unusual occurrence...does not replace your requirement to notify all required regulatory or enforcement

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entities...The form is to be completed entirely..." The policy included fill in the blank areas with specific details and a description page to document subjectively.

A policy titled, "Abuse, Neglect and Exploitation" documented, "...Neglect means failure of the facility, the employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress...interview the involved resident, if possible, and document all responses...if cognitively impaired, interview the resident several times to compare responses...interview the resident's family...or other individual's involved in the resident's life...interview witnesses separately...include roommates, resident's in adjoining rooms, staff members in the area, and visitors in the area. Obtain witness statements...All statements should be signed and dated by the person making the statement...document the entire investigation chronologically...Anyone in the facility can report....notify DON and administrator (document), initiate investigation immediately, Notify the attending physician, resident's family...obtain witness statements..."

No further information and or documentation was provided prior to the exit conference on 05/171/17 at 9:00 a.m., to evidence that the facility staff followed written policies and/or procedure for the prevention of abuse, neglect and/or exploitation for Resident # 5.