PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		<u> </u>	OME	3 NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X:	3) DATE SURVEY COMPLETED
		495102	B. WING _			C 08/06/2015
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE	E, ZIP CODE	
ĺ		TOTO ADI INICTONI		550 SOUTH CARLIN SPRINGS	S ROAD **REVISE	D**
MANUKU	CARE HEALTH SERVI	CES-ARLINGTON		ARLINGTON, VA 22204	1111 - 1111	
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F 000	INITIAL COMMENT	rs	FO	00		
F 221 SS=D	survey was conduct 08/06/15. Signification compliance with 42 Term Care Require investigated during Code survey/report.  The census in this 130 at the time of the consisted of 23 curre (Residents #1 through 27) and 4 center (Resident's #22 through 28 through 27 through 29 th	161 certified bed facility was he survey. The survey sample rent resident reviews ugh 21 and Residents # 26 closed record reviews rough 25). TO BE FREE FROM	F 2	221		
	physical restraints in discipline or convert reat the resident's.  This REQUIREMENT by: Based on staff intered and facility docume	ne right to be free from any imposed for purposes of nience, and not required to medical symptoms.  NT is not met as evidenced erview, clinical record review, ent review, the facility staff		Past noncompliance: correction required.	no plan of	
	failed to ensure one sample was free from Resident # 17.  The facility staff helphysically restraining incontinence care, to the sample of the	e of 27 residents in the survey om physical restraints,  Id Resident # 17's hands, and the resident during which resulted in bruising and sident's arms and hands.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

lemmis

(X6) DATE

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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		AND HUMAN SERVICES  & MEDICAID SERVICES				MAPPROVED ), 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
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F 221	Continued From pa	age 1	F 2	21			
	11/18/12. Diagnos but were not limited (peripheral vascula	admitted to the facility on es for Resident # 17 included, f to: Alzheimer's disease, PVD r disease), HTN (high blood ion, and muscle weakness.	ı				
And and an opposite the same of the same o	quarterly assessme assessed the resid "7" indicating the re in daily decision ma	MDS assessment was a ent dated 05/19/15. This MDS ent with a cognitive score of esident had severe impairment aking skills. This MDS also ent as requiring extensive					

The most current full MDS (minimum data set) with CAAS (care area assessment summary) was reviewed for comparison, dated 11/16/14. This MDS assessed the resident with a cognitive score of "4", again indicating the resident had severe impairment in daily decision making skills and as requiring extensive assistance from staff for toileting with at least one person physical assist. Additionally, the resident was assessed as 'not having behavior symptoms and as 'not' resisting care. The resident triggered in the CAAS area of this MDS for: cognition, communication, mood

assistance with toileting with at least one person physical assist. Additionally this MDS assessed the resident as 'not' having behavior symptoms

and as 'not' resisting care.

A review of a FRI (facility reported incident) alleged that on 06/06/15, Resident # 17 sustained three skin tears with bruising to the right wrist during incontinence care by two CNA (certified nursing assistants), CNA#3 and CNA#4.

During clinical record review on 08/05/15 and

and urinary.

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

PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

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FICIENCIES RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			SURVEY PLETED
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			PERCENT ADDRESS CITY STATE 712 CO		0,20,0
NAME OF PROVIDER OR SUPPLIER					
HEALTH SERV	ICES-ARLINGTON	1	,	D **REVISED**	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
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F 221 Continued From page 2

08/06/15 nursing notes were reviewed for Resident #17.

A nursing note dated 06/06/15 and timed 8:32 a.m., documented: "Resident is alert and verbally responsive resident sustained skin tear on right arm, during incontinence care trying to scratch the CNA (certified nursing assistant), patent (sic) was very combative, kicking and scratching the CNA, refused for the writer to give skin care, slap (sic) the writer on the face, also refused the supervisor, son was put on the phone the patent (sic) refused to talk to him, MD (medical doctor) notified new order to apply triple antibiotic ointment and cover with gauze..."

A nursing note dated 06/06/15 and timed 11:32 p.m., documented: "...Pt (patient) has bruises on her Rt (right) arm due to pt kicking and resisting care this morning. Area is red but not bleeding noted (sic)...Investigation done to find out cause. Family requested incident report written by the nurse on duty that time but it was not granted..."

A nursing note dated 06/06/16 and timed 11:48 p.m. documented: "Head to toe assessment was completed, on assessment patient is noted with right lower arm skin tears, with bruising surrounding the skin tears that measures 14cm (centimeters) X (by) 4.5cm. Left lower arm and hand is noted with discoloration in several areas of the arm. First area measures 3cm X 2.5cm closed discolored area that is purplish in color that is on the left outer aspect of the arm. Second area measures 2cmX 2cmX closed that is red/purplish discoloration that is on the back of the left hand between the thumb and index finger. Third area measures 1cm X 0.5cm that is red/purplish...closed..."

F 221

Facility ID: VA0155

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	B. WING		08/06/2015
NAME OF PROVIDER OR SUPPLIE  MANORCARE HEALTH SER		55	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH CARLIN SPRINGS ROAD **REV RLINGTON, VA 22204	ISED**
OPERLY (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION

### F 221 Continued From page 3

A nursing noted dated 06/06/15 and timed 11:48 p.m. documented: "...skin tears that was sustained during ADL (activities of daily living) care...3 skin tears to the right arm...1.5 cm X 2 cm...1cm X 2cmX...0.3 cm X 1.2 cm..."

A nursing note dated 06/07/15 and timed 4:35 p.m., documented: "...Resident very combative refused ADL's during this shift...X-ray of right wrist...pending result..."

Resident'# 17's current CCP (comprehensive care plan) was then reviewed and documented the following: "...Assist with daily hygiene, grooming, dressing...break ADL tasks into sub-task for easier patient performance...Allow for flexibility in ADL routine to accommodate mood, preferences, and customary routine...Elicit family input for best approaches; ask physician to explain/reinforce need for treatment...If resident refuses contact son to speak with resident and explain care in Spanish...if resists care, leave (if safe to do so) and return later...Do not invade personal space...Elicit family input for best approaches...Talk with in a low pitch, calm voice to decrease/eliminate undesired behavior...Allow adequate time to respond. Do not rush or supply words...Approach/speak in calm, positive /reassuring manner...Explain each activity/care procedure prior to beginning it...Gain individual's attention before beginning...Provide assistance as needed...provide incontinence care as needed...psych consult as needed..."

On 08/06/15 at approximately 8:00 a.m., the assistant administrator was asked for the investigation, abuse policy, along with the x-ray reports and any psych consults regarding

F 221

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				550 5	SOUTH CARLIN SPRINGS ROAD **RE\	/ISED**	
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E 221	Continued From pa	ne 4	F 2	121			
1 221	Resident # 17.	ge 4	! 2	.2 1			
	Resident# 17.						•
	The investigation su	ımmary was presented and					
		stigation was completed by					
		of nursing) on 06/12/15. The ary documented: "On					
		mately 5:30 a.m. (Resident #					
	17) sustained 3 self	finflicted skin tears to her right					:
		continence). The two staff					
		patients hands while rm incontinence careCNA#					
		ide incontinence care and					
	Resident # 17 refus	edCNA # 3 and CNA # 4					
		ontinence care for Resident #					
		was yelling in another er feet and attempted to					
	scratch and bite CN	IA#3, CNA#4 tried to			•		
	explain that they we	ere trying to clean					
		continued to yell, kick and					
	tried to scratch CN/	A # 3, CNA # 3 was holding he could not hit them while					
	CNA # 4 was chang	ging herConclusion: Based					•
	on the investigation	including resident (other					
	residents in the fac	ility) and staff interviews it was					į
		use did not occur. The staff					
	members used the	r best judgement in providing it and the self inflicted skin			•		
	tears were accident	tal and the staff reacted to the					
	resident's resistance	e to care. Their actions were					
	not to intentionally	cause harm."					
	Employee statemer	nts documented the following:					
	CNA#3 (06/06/15) the room at 4 am to	(via telephone)- "I went into change her. She did not let					

me...she was sitting in the chair and the bed was wet with urine and stool, so I changed the bed linens while she was in the chair...she had stool all over herself. I grabbed her depend and

Facility ID: VA0155

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	n page 5 r and said let me change you.	F 221			

She grabbed the depend out of my hand and placed it under her arm and got back into the bed...covered herself up with the coat. When I kept asking her to let me change you she kept saying no, ...told the nurse...nurse on duty told me to go get the other CNA (CNA # 4) to help me...around 5 am we both entered the room...asked her to let us change her and she kept saying no...While I was in the room with CNA #4 she told me to watch her lead, so CNA#4 took a new depend and showed it to her and said your wet we are going to change you. So CNA# 4 started to get the wet clothes off of her and she started to kick, hit, and scratch. I was holding her hands so she could not hit us. So when I was holding her hand she went to scratch me on my hand that's when I moved...and she scratch (sic) herself...CNA#4 and I kept cleaning her when we got the clothes and depends off her she had dried stool all over her buttocks and down to her legs...saturated with urine and stool, we gave her a bed bath and wiped her real good to clean her up...got her dressed and cleaned. When we were done she grabbed her walker and threw it at us and the shoes hit the bathroom door...I went to the nurse to tell her that the resident had a skin tear from changing her .... "

CNA # 4 (06/08/15)- "...I was not assigned to take care of Resident # 17...at approximately 5 a.m....I was asked by CNA # 3 to assist her with incontinence care for Resident # 17...CNA # 3 was already in the room when I came to assist her. Resident # 17 was yelling words I could not understand. I tried to explain to her that we needed to clean her. She was covered in bowel movement and was really dirty and needed to be changed. Resident # 17 continued to yell out and

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		495102	B. WING	j			C 08/06/2015
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	<u>,</u>	1 -	EET ADDRESS, CITY, STATE, ZIP C	. –	
MANORO	CARE HEALTH SERVI	CES-ARLINGTON		1	SOUTH CARLIN SPRINGS ROAL LINGTON, VA 22204	D **REVISE	D**
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	
F 221	and bite her hands. and try to scratch CNA # 3 held her have were done chan hand was bleeding. The x-ray report for and documented not dislocation.  The psych consults the following:  02/18/15 "Geriatricaggression, psych refusals, stable on eis variable, episodic remeronstates sh with staff to discuss agitation, ways to return to be fam neglectAbuse car varying degreespl slapping, pinching, educated upon hire prevention"  The administrator, If the assistant admin concerns regarding physically restrained and sustaining multial meeting with the staff with the staff to discuss agitation and sustaining multial meeting with the staff to discuss agitation and sustaining multial meeting with the staff to discuss agitation and sustaining multial meeting with the staff to serve the staff to discuss agitation and sustaining multial meeting with the staff to serve t	was trying to scratch CNA # 3she continued to yell, kick actually scratched herself. So ands and I wiped herwhen ging her we say that her right"  Resident # 17 was reviewed egative for fracture or  were reviewed and revealed  Psychiatry Progress Note: nosiscombative with care, examstaff note that agitation e he was just started on e is content, mood goodmet a strategies for staff to manage edirect and distract"  policy documented: "it is illiardefinitions of abuse, n occur in many forms and to hysical abuse includes hitting, and kickingemployees are and annually on abuse  DON (director of nursing), and istrator were informed of Resident # 17 being d during incontinence care iple skin tears and bruising, in survey team on 08/06/15 at	F	221			
	approximately 10:00						

The DON voiced that the staff used their best

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CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES						. 0938-0391
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		495102	B. WING			1	C (06/2015
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-ARLINGTON	<u>-</u>		SOUTH CARLIN SPRINGS ROAD **R LINGTON, VA 22204	EVISED**	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 221	resident's CCP and	ge 7  ON was informed about the that this was an identified ent and the CCP was not	F2	221			
	followed, the staff nresident alone and resident's family for resident being restresident incurred physically held dow DON was asked whocumented in the	nembers did not leave the did not attempt to contact the any guidance prior to the ained, and as a result the hysical injury from being in by the staff members. The last are/were the 'strategies', psych consult. The DON ining to what was in the					
	on the resident atte DON was informed statements of the st repeatedly told the s physical resistance members continued point of physical resinformed that accor- facility staff did not to care resistance for	mpting to hit the staff. The that according to the that according to the taff members, the resident staff members no, prior to any from the resident and the staff, provoking the resident to the istance. Again, the DON was ding to the evidence the follow the resident's CCP for Resident # 17, and as result d physical injury.					
	The facility submitte non-compliance.	d evidence for past					
	The facility 's plan of	of correction was as follows:					
	notified. Orders we skin tears and the tr	d responsible party were re obtained for the patient 's eatment was administered. A					

well as a pain evaluation and Braden Skin Risk assessment. The physician ordered lab work (UA/C&S), wrist x-ray, and a psyche consult. A

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CENTER	& MEDICAID SERVICES	,		MB NO.	0938-0391		
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NAME OF F	PROVIDER OR SUPPLIER		<u>'                                    </u>	s	STREET ADDRESS, CITY, STATE, ZIP CODE	· · · ·	
*******	NAME HEALTH CEDIG	OFC ARLINGTON		5	50 SOUTH CARLIN SPRINGS ROAD **REV	ISED**	
MANURU	CARE HEALTH SERV	CES-ARENIGION	l	A	ARLINGTON, VA 22204		
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F 221	Continued From pa	ge 8	F 2	221			
	•	on was completed. The care					
		and the involved employees					
	were educated prio						
		sident Rights related to					
	interventions.	efuse care, and behavioral					
	interventione.						
	combative behavior	ve during care and /or with s have the potential to be					
	affected. An audit	was completed to identify behavioral symptoms. The					
		riewed to ensure that					
		rategies were care planned to					
	address behavioral						
	3 Staff education v	vas completed on Resident			•		
	Rights related to re	straints, right to refuse care,					
	and behavioral inte	rventions. The ADNS and/or					
		ete random weekly audits for					
		tients with identified behaviors opriate care strategies are					
		opriate care strategies are not of care. Compliance with the					
•		uidelines/systems is					Ì
		the daily QAA process.					
		ns will be reviewed by the imittee. Recommendations					
	for further corrective	e action will be discussed and					
	implemented as ne	eded.					
	5. Corrective action	n was completed 7-6-15.					
		on or documentation was					,
	provided or present						
		ence that Resident # 17 was lined by staff during					
		r that the resident's	٠				

comprehensive plan of care was followed

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

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	S . OMB NO. 0938-0					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST			(X3) DATE : COMPL	
		495102	B. WING			_	08/06	5/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STA	TE, ZIP CODE		·
MANOR	CARE HEALTH SERVI	CES-ARLINGTON		550 SOUTH CARLIN SPRINGS ROAD **REVISED** ARLINGTON, VA 22204				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFII TAG		(EACH CORRECTIVE ROSS-REFERENCED		8E	(X5) COMPLETION DATE
F 221	Continued From paregarding the above	ge 9 e issues and concerns.	F 2	21				
	Past Non- complian 483.13(c) PROHIBI MISTREATMENT/N		F 2	24				
	policies and proced mistreatment, negle	velop and implement written ures that prohibit ect, and abuse of residents on of resident property.						
	by: Based on staff inte	.  Note that as evidenced review, clinical record review,			noncompliance	o: no plan of		1
	failed to ensure one	nt review, the facility staff of 27 residents in the survey om mistreatment, Resident #		corre	ction required.			
	17's hands during in	rsically restrained Resident # ncontinence care, which bruises and skin tears to the hands.						
	Findings include:							
	11/18/12. Diagnose but were not limited (peripheral vascular	admitted to the facility on es for Resident # 17 included, to: Alzheimer's disease, PVD disease), HTN (high blood on, and muscle weakness.						

The most current MDS assessment was a

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		ATE SURVEY OMPLETED
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NAME OF	PROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP COD	Œ	
MANOR	CARE HEALTH SERVI	CES-ARLINGTON			SOUTH CARLIN SPRINGS ROAD LINGTON, VA 22204	**REVISED**	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 224	assessed the reside "7" indicating the re in daily decision ma assessed the reside assistance with toile physical assist. Addithe resident as 'not' and as 'not' resisting  The most current for with CAAS (care and reviewed for compa MDS assessed the of "4", indicating the impairment in daily requiring extensive toileting with at leas Additionally, the resident for: cognition, compa A review of a FRI (for alleged that on 06/0 three skin tears with during incontinence nursing assistants),  During clinical recor 08/06/15 nursing no Resident # 17.  A nursing note date a.m., documented:	ent dated 05/19/15. This MDS ent with a cognitive score of sident was severe impairment liking skills. This MDS also ent as requiring extensive eting with at least one person ditionally this MDS assessed having behavior symptoms		224			

arm, during incontinence care trying to scratch the CNA (certified nursing assistant), patent (sic) was very combative, kicking and scratching the

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495102	B. WING	· 		08	C 8/06/2015
NAME OF F	PROVIDER OR SUPPLIER		· · · · ·	S	FREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERV	CES-ARLINGTON		1	50 SOUTH CARLIN SPRINGS ROAD **R RLINGTON, VA 22204	EVISED**	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 224	Continued From pa	ge 11	F	224			
	(sic) the writer on the supervisor, son was	ne writer to give skin care, slap ne face, also refused the s put on the phone the patent to him, MD (medical doctor)					
	p.m., documented: her Rt (right) arm d care this morning. noted (sic)Investi Family requested in	d 06/06/15 and timed 11:32 "Pt (patient) has bruises on ue to pt kicking and resisting Area is red but not bleeding gation done to find out cause. icident report written by the ime but it was not granted"					
	p.m. documented: completed, on asseright lower arm skir surrounding the ski (centimeters) X (by hand is noted with cof the arm. First arclosed discolored a that is on the left ou Second area meast that is red/purplish aback of the left hand	d 06/06/16 and timed 11:48 "Head to toe assessment was essment patient is noted with tears, with bruising in tears that measures 14cm and discoloration in several areas ea measures 3cm X 2.5cm area that is purplish in color atter aspect of the arm.  The second of the arm and discoloration that is on the discoloration."					
	p.m. documented: sustained during AL care3 skin tears to	ed 06/06/15 and timed 11:48 "skin tears that was DL (activities of daily living) the right arm1.5 cm X X0.3 cm X 1.2 cm"					

A nursing note dated 06/07/15 and timed 4:35 p.m., documented: "...Resident very combative refused ADL's during this shift...X-ray of right

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	OC TOD MEDICADE	& MEDICAID SERVICES				NO. 0938-0391
				TI S CONSTRUCTION		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		495102	B. WING _	•		C 08/06/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		00,00,20
			ł	550 SOUTH CARLIN SPRINGS RO		
MANORO	ARE HEALTH SERVI	CES-ARLINGTON		ARLINGTON, VA 22204		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE 1E APPROPRIATE	(X5) COMPLETION DATE
F 224	Continued From pa	ge 12	F 22	.4		
	wristpending resu	lt"				
	care plan) was ther the following: "As grooming, dressing sub-task for easier for flexibility in ADL mood, preferences, family input for best explain/reinforce nerefuses contact sor explain care in Spa safe to do so) and a personal spaceEl approachesTalk w to decrease/elimina adequate time to rewordsApproach/s/reassuring manner procedure prior to be attention before begas neededprovide neededpsych cor					
•	assistant administration, abuse	roximately 8:00 a.m., the ator was asked for the epolicy, along with the x-ray who consults regarding				
	reviewed. The invette DON (director of investigation summo6/06/15 at approximation)	ummary was presented and estigation was completed by of nursing) on 06/12/15. The ary documented: "On mately 5:30 a.m. (Resident # f inflicted skin tears to her right				

arm during care (incontinence). The two staff members held the patients hands while

Facility ID: VA0155

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0		0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		ONSTRUCTION			E SURVEY PLETED
		495102	B. WING				l	C 06/2015
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP C	ODE		
MANORO	MANORCARE HEALTH SERVICES-ARLINGTON				SOUTH CARLIN SPRINGS ROAL INGTON, VA 22204	) <u>**</u> REVI	SED**	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 224	3 attempted to prove Resident # 17 refusivent to provide incomparison of the provide incomparison of the provide incomparison of the provide incomparison of the investigation interviews it was described in the staff reacted to care. Their actions cause harm."  Employee statement CNA # 3 (06/06/15) the room at 4 am to meshe was sitting wet with urine and so linens while she was all over herself. I grand showed it to her and She grabbed the deplaced it under arm bedcovered herself kept asking her to lessaying no,told the	im incontinence careCNA # ide incontinence care and ideCNA # 3 and CNA # 4 ontinence care for Resident # was yelling in another er feet and attempted to IA # 3, CNA # 4 tried to ere trying to clean continued to yell, kick and A # 3, CNA # 3 was holding the could not hit them while ging herConclusion: Based including resident and staff termined that abuse did not embers used their best ling care for the resident and in tears were accidental and the resident's resistance to were not to intentionally into change her. She did not let in the chair and the bed was atool, so I changed the bed in the chairshe had stool as in the chair and the bed was atool, so I changed the bed in the chair and the bed was atool, so I changed the bed as in the chairshe had stool as in the chair and the bed was atool, so I changed the bed and got back into the eff up with the coat. When I get me change you she kept on ursenurse on duty told her CNA (CNA # 4) to help	F	224				

room...asked her to let us change her and she kept saying no...While I was in the room with CNA

		AND HUMAN SERVICES  & MEDICAID SERVICES			FOR	D: 08/21/2015 M APPROVED D: 0938-0391		
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION AND IMPED		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		495102	B. WING		08	B/06/2015		
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-ARLINGTON		STREET ADDRESS, CITY, STATE, ZIP C 550 SOUTH CARLIN SPRINGS ROA ARLINGTON, VA 22204				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE		
F 224	took a new depend your wet we are got 4 started to get the started to kick, hit, a hands so she could holding her hand sh hand that's when I herselfCNA # 4 a we got the clothes a dried stool all over legssaturated with a bed bath and wip upgot her dressed were done she graft us and the shoes he the nurse to tell her tear from changing	watch her lead, so CNA # 4 and showed it to her and said ing to change you. So CNA # wet clothes off of her and she and scratch. I was holding her I not hit us. So when I was ne went to scratch me on my movedand she scratch and I kept cleaning her when and depends off her she had her buttocks and down to her h urine and stool, we gave her ed her real good to clean her d and cleaned. When we bed her walker and threw it at it the bathroom doorI went to	F 2	224				

CNA# 4 (06/08/15)- "...! was not assigned to take care of Resident # 17...at approximately 5 a.m....! was asked by CNA# 3 to assist her with incontinence care for Resident # 17...CNA# 3 was already in the room when I came to assist her. Resident # 17 was yelling words I could not understand. I tried to explain to her that we needed to clean her. She was covered in bowel movement and was really dirty and needed to be changed. Resident # 17 continued to yell out and kicked her feet and was trying to scratch CNA# 3 and bite her hands...she continued to yell, kick and try to scratch...actually scratched herself. So CNA# 3 held her hands and I wiped her...when we were done changing her we say that her right hand was bleeding..."

The x-ray report for Resident # 17 was reviewed and documented negative for fracture or dislocation.

Facility ID: VA0155

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
•		495102	B. WING			30	C 3/ <b>06/2015</b>
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-ARLINGTON		550	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH CARLIN SPRINGS ROAD ** LINGTON, VA 22204		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 224	Continued From pa	ge 15	F 2	24			
	The psych consults the following:	were reviewed and revealed					
	aggression, psych refusals, stable on is variable, episodic remeronstates sh with staff to discuss	Psychiatry Progress Note: nosiscombative with care, examstaff note that agitation is she was just started on the is content, mood goodmet is strategies for staff to manage edirect and distract"					
	agitation, ways to redirect and distract"  The facility's abuse policy documented: "it is important to be familiardefinitions of abuse, neglectAbuse can occur in many forms and to varying degreesphysical abuse includes hitting, slapping, pinching, and kickingemployees are educated upon hire and annually on abuse prevention"						
	the assistant admin concerns regarding physically restraine and sustaining mult	DON (director of nursing), and istrator were informed of Resident # 17 being d during incontinence care iple skin tears and bruising, in survey team on 08/06/15 at 0 a.m.					
	judgement and that intentionally hurt. T the resident's CCP identified issue (20° combativeness and The DON was also	at the staff used their best the resident was not the DON was informed about addressing an already (12) with this resident regarding resistance to care at times. made aware that the CCP he staff members did not leave					

the resident alone and did not attempt to contact the resident's family for any guidance prior to physically restraining the resident and as a result

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		& MEDICAID SERVICES					IO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) D	OATE SURVEY OMPLETED
			B. WING				С
		495102	B. WING			<u> </u>	8/06/2015
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	CES-ARLINGTON			SOUTH CARLIN SPRINGS ROAD **F LINGTON, VA 22204	EVISEU	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 224	members. The DO staff members have should have followed. The DON further voon the resident atte DON was informed statements of the strepeatedly told the sany physical resista staff members contiask completion, with physically resist. The were made aware to and obviously, that resident and staff munderstand, but refunderstand, but refunderstand, but refunderstand and followed ocumented and followed ocumented and followed ocumented injury.	d physical injury by the staff N was asked what should the e done. The DON voiced, they ed the care plan.  Diced that staff reacted based impting to hit the staff. The that according to the taff members, the resident staff members "No", prior to ince from the resident and the inued for their convenience or nich provoked the resident to the DON and administrator hat the word, "no" means "no" was a word that both the nembers know and used to listen to the resident. The med that if staff had not wed the resident told them "No" resident may have not	F	224			
	The facility submitte non-compliance.	ed evidence for past					
	The facility 's plan	of correction was as follows:					
	notified. Orders we skin tears and the to head to toe skin asswell as a pain evaluassessment. The (UA/C&S), wrist x-ra	nd responsible party were are obtained for the patient 's reatment was administered. A sessment was completed as lation and Braden Skin Risk physician ordered lab work ay, and a psyche consult. A on was completed. The care					

plan was updated, and the involved employees were educated prior to returning from

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES		#	OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495102	B. WING		C 08/06/2015
NAME OF E	PROVIDER OR SUPPLIER		٦	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,00,2010
7.0.10.2.0	1,01,021,011,011		l	550 SOUTH CARLIN SPRINGS ROAD **RE	VISED**
MANORO	CARE HEALTH SERV	ICES-ARLINGTON		ARLINGTON, VA 22204	11025
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		LD BE COMPLETION
F 224	Continued From pa	ige 17	F 2	274	
	suspension, on Abu	=	, _	. <b>6</b> -7	
	Head to toe body a	ve the potential to be affected. udits on residents in the s assignments and resident			
	Abuse policy. The complete random won like patients to e	vas completed on the facility e ADNS and/or designee will veekly audits for three months ensure that appropriate care ified in the plan of care.			
	facility 's QAA Com	ns will be reviewed by the mittee. Recommendations e action will be discussed and eded.			
	5. Corrective action	n was completed 7-6-15			
	provided or present	ion or documentation was led prior to the exit ence that Resident # 17 was			
	restrained by staff of the resident repeate "No." The resident	sult of being physically furing incontinence care after edly told the staff members, s comprehensive plan of care garding the above issues and		,	
F 279 SS=D	Past non-compliand 483.20(d), 483.20(k COMPREHENSIVE	:)(1) DEVELOP	F 27	79	
	A facility must use t	he results of the assessment			

to develop, review and revise the resident's

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		AND HOWAN SERVICES					APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES			<del>,</del>			<u>DWR NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	, cor	E SURVEY MPLETED
		495102	B. WING				C /06/2015
NAME OF F	PROVIDER OR SUPPLIER		<u>'</u>	ST	REET ADDRESS. CITY, STATE, ZIP CODE		· · · · · · · · · · · · · · · · · · ·
				55	0 SOUTH CARLIN SPRINGS ROAD **RE	VISED**	
MANORO	CARE HEALTH SERVI	CES-ARLINGTON		Al	RLINGTON, VA 22204		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x ,	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	Continued From pa	ine 18	F 2	79	F 279 Develop Comprehensive	e Care	
. 2.3	comprehensive plan	-			Plans		
	Comprehensive plan	ii oi care.			4		
	The facility must de	evelop a comprehensive care			The facility will continue to us	se the	
		ent that includes measurable			results of the assessment to de		
		etables to meet a resident's			review and revise the resident	.'s	
	medical, nursing, a	nd mental and psychosocial			comprehensive plan of care.		
	needs that are iden	tified in the comprehensive					
	assessment.				<ol> <li>Resident # 9 the Care Area S</li> </ol>		
					Sheet was reviewed to ensure the		
	The care plan must	t describe the services that are			that were triggered and coded to	proceed	İ
		ittain or maintain the resident's			to care plan did in fact have a c	are plan	
		physical, mental, and			developed.		
	psychosocial well-b	eing as required under					
	§483.25; and any s	ervices that would otherwise §483.25 but are not provided			<ol><li>Comprehensive MDS assess</li></ol>	nents of	
	be required under g	s exercise of rights under			current residents were reviewed		
	11 September 2009 Of September 2009	the right to refuse treatment			that Care Areas that were trigge		
	under §483.10(b)(4				plan had a care plan in place. C	Care plans	3
	under 9405. ro(b)(4	')•			were initiated as appropriate.		
	This DECUIDENCE	NT is not met as evidenced			3. The Interdisciplinary Team	received	_
	by:	141 Is not met as evidenced		•-	education by the ADNS or desi		
	Based on staff inte	erview and clinical record			regarding the necessity of ensur		a
		staff failed to develop a			care plan is developed based or	n the	
	Comprehensive Ca	are Plan (CCP) for one of 27			assessment and Care Areas that	are	
		vey sample: Resident's #9 .			triggered to proceed to care pla		
	Resident #9 did not	t have a care plan to address			The MDS coordinator and/or d	esignee v	vill
	pressure ulcers or i				complete random weekly audit		
	•				Area Assessment Summaries to	ensure	
•	Findings include:				that all areas coded to proceed		an
					are addressed in the plan of car	e. for 90	
		dmitted to the facility 12/15/11 n 6/9/15 with diagnoses			days.	,	

including but not limited to: Glaucoma, muscle

The most recent MDS (minimum data set) was a

weakness, dementia, chronic obstructive

pulmonary disease, and hypertension.

4. Identified concerns will be reviewed by

the facility's QAA Committee.

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

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				<u>ив NO.</u>	<u>0938-0391</u>	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	,	495102	B. WING				) 06/2015	
NAME OF F	ROVIDER OR SUPPLIER			Ş	TREET ADDRESS, CITY, STATE, ZIP CODE			
		OFO ADI MOTON		55	50 SOUTH CARLIN SPRINGS ROAD **REVI	SED**		
MANORO	ARE HEALTH SERVI	CES-ARLINGTON		Α	RLINGTON, VA 22204			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 270	Continued From pa	ge 19	F 1	279				
F 219				213	Recommendations for further corre			
	quarterly assessment dated 6/2/15. Resident #9 was assessed as being cognitively intact with a score of 15 of 15.				action will be discussed and imple as needed.	mentea		
		to all account of the control of the			5. September 4, 2015			
	8/5/15 and revealed care area assessm care area's of "pres column "A Care Are Under column "B A	ical record was reviewed on d a full MDS dated 2/8/15 with ent section "V" (CAA's). In the sure ulcers and incontinence", a Triggered" was checked. ddressed in Care Plan" was ating a care plan was put in #9.						
	Review of Resident evidence that a car above area's.	t #9's care plan did not show e plan was created in the						
	attention of the MD nurse, RN #2) on 8 time RN #2 also retriggers and the catwo area's in questidue to assessment	tion was brought to the S coordinator (registered /5/15 at 10:45 a.m. At this viewed the MDS care area's re plan and verbalized that the ion should have a care plan s evidencing incontinence d cause skin break down.						
	surveyor and verba care plans in quest canceled when Res the hospital and did	o.m. RN #2 approached this dized after investigating the ion, the care plans were sident #9 was discharged to dinot get added to the care dinave been, when Resident to the facility.						
	the administrator a 8/5/15 at 4:30 p.m.	was brought to the attention of nd director of nursing on No further information was he exit conference 8/6/15.						

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

PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u>O</u>	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					· · · · · · · · · · · · · · · · · · ·	С
		495102	B. WING			08/06/2015
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	
MANORO	ARE HEALTH SERVI	CES-ARLINGTON		Ī	SOUTH CARLIN SPRINGS ROAD "REV	'ISED**
				ARI	LINGTON, VA 22204	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 281	Continued From pa	ge 20		281	F 281 Professional Standards	
F 281	483.20(k)(3)(i) SER	VICES PROVIDED MEET	F	281	F 281 Professional Standards	
SS=D	PROFESSIONAL S	TANDARDS			The facility will continue to pro	vide
	The services provid	ed or arranged by the facility			services that meet professional	•
		onal standards of quality.			standards.	
					1. Resident #24 no longer resides	in the
	This REQUIREMEN	NT is not met as evidenced			facility.	,
	by:				LPN #4 has received a CPR skills	review
	Based on staff inte	rview, facility document			via a certified CPR instructor.	
		rd review and in the course of				
		gation, the facility staff failed			2. An audit of licensed nurses was	
		standards of nursing by using cardiopulmonary resuscitation)			completed by Human Resources t	
		7 residents in the survey			that their CPR certification is curr	rent.
·	sample (Resident #	24).			3. Nurses will receive Cardio Puli	monary
	A PONT OF A COURT OF A COURT				Resuscitation (CPR) certification	
		operly position her hands upon est. LPN # 4 performed CPR			certified CPR instructor.	·
		the xyphoid process (the			HR will obtain current CPR crede	entials for
		n at the lower end of the			all new hires and maintain a	
	sternum) instead of	the middle of sternum. By			log/spreadsheet to track the certifi	
		ver the xyphoid process, LPN			HR will inform the Administrativ	e
	#4 caused the comp	pressions to be ineffective.			Director of Nursing Services of certifications that are soon to be d	ue for re-
					certification.	uc for to-
	Findings included:				Mock Codes will be held weekly	on each
	·				shift for 30 days and then 3 times	
		dmitted to the facility on			for 60 days.	
		gnoses including, but not				
		ow knee amputation, wound			4. Identified concerns will be revi	ewed by
	diabetes molitus M	vascular disease and o MDS (minimum data set)			the facility's QAA Committee.	
	had been completed	d for this resident, but he was			Recommendations for further con action will be discussed and imple	
		ical record as alert and			as needed.	Jinonited
	oriented v 4				as necucu.	

On 08/05/2015 at approximately 2:20 p.m. Resident #24's clinical record was reviewed. A

5. September 4, 2015

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		& MEDICAID SERVICES						938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		405400	B. WING				C	0/0045
		495102	B. WING			<u> </u>	08/00	6/2015
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE,			
MANORO	ARE HEALTH SERVI	CES-ARLINGTON			OUTH CARLIN SPRINGS IGTON, VA 22204	ROAD **REVIS	ED**	
				ACCIT		T.00005071011		<del></del>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD E THE APPROPRI	_	(X5) COMPLETION DATE
F 281	Continued From pa	age 21	F:	281				
	progress note writte practical nurse) sta unresponsive at 3.1	en by LPN #4 (licensed ted, "pt (patient) noted 10 am (3:10 a.m.) 911 was nonary resuscitation)						
	08/06/2015 at apprint the "Code Blue" incompleted. The DC investigation. We dimproper CPR being anything to us about licensed personnel certification prior to DON stated, "Yes." nursing assistants) nurses required to employment? The checked off on skill look into this further	of nursing) was interviewed on oximately 7:55 a.m. regarding sident with Resident #24 on vestigation of the incident was DN stated, "There was no didn't know anything about 10 done. The police didn't say 11 this." The DON was asked if are required to have CPR working at the facility. The Nurses and CNA's (certified, "No, just nurses." Are complete a skills checkoff on DON stated, "Nurses are 1s during orientation. Let me 1s and 1 will get back with you"						
	"(Name) LPN #4 di the bedside commo had a pulse. They	:40 a.m. the DON stated, d start CPR. He was up on ode and didn't look well. He assisted him to bed and alse found. CPR was initiated."						
	11/2013, was review	lanagement" policy, Revised wed. At approximately 10:05 s asked if "Mock Drills" are cility as stated in the policy.						,
	interviewed at appr if current CPR certi	sources) Director was oximately 11:20 a.m. regarding ifications are kept in the e HR Director stated, "If they	!					

PRINTED: 08/21/2015

		AND HUMAN SERVICES					PROVED
		& MEDICAID SERVICES			1B NO. 09		
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION	ľ	X3) DATE SI COMPLE C	
		495102	B. WING			08/06	2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-ARLINGTON		550 SOUTH CARLIN SPRING ARLINGTON, VA 22204	S ROAD **REVIS	SED**	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD E TO THE APPROPRI		(X5) OMPLETION DATE
F 281	Continued From pa	ge 22	, F2	281			
	have one we make	a copy. If there isn't one in					
		an they don't have one. We					
		s copies when they get a new any CPR certification was					
		employee file. "I guess my					1
	predecessor didn't	get copies either. I have been					
		ce 2013. I need to use					
	another system to k certifications so I ca						
	Certifications so rec	an stay on them.					
		pproximately 1:25 p.m., LPN					
		by the survey team regarding 5 and early morning of					
		stated, "I came in, made					
	rounds. (Name) Re	esident #24 was sitting on the					
	side of his bed. I no	ormally work on the second					
	tioor, but tonight I w	as on three. I went back to after rounds to check and see					
		troduced myself and gave him					i
	his call light and to	call if he needed anything.					
	(Name) Resident #	24 stated I am fine and okay.					
	After I did my twelve	e o'clock meds (medications)					
	and treatments I ch	ecked on (Name) Resident					
	#24 again. I took h	is vital signs and blood sugar, mal. He was laying in bed. He					
		ed out on his call bell about 30					
	minutes later reque	sting something for pain. I					
		He (Resident #24) called out					
	again about 30 min	utes later wanting his pillow hour later he (Resident #24)					
	called and the tech	went to his room and I came					
	in a minute later. H	le needed to use the					
	commode Lofferer	d him a hednan and he said					1

resident while he was up.

no, I need a commode. We went and got a bedside commode. The tech and myself helped him up to the commode because he was a below the knee amputee. I told the tech to stay with the

Facility ID: VA0155

PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		495102	B. WING		80	/06/2015
	IDER OR SUPPLIER HEALTH SERV	ICES-ARLINGTON		STREET ADDRESS, CITY, STATE, ZIP COL 550 SOUTH CARLIN SPRINGS ROAD ARLINGTON, VA 22204		
(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 CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

### F 281 Continued From page 23

The tech left the room to answer another call light and I went into the room. (Name) Resident #24 said I need to have a BM (bowel movement) and I don't want anyone watching me. I placed the call light in reach, told him to call if he needed anything and I went to the nurse's station to get a drink of water. A few minutes later I checked on the resident and he was not done. He said I will call when I am finished. I went back to the nurse's station. A few minutes later the tech went to check on the resident and yelled out for the nurse standing in the hall. I also went to the resident's room. (Name) Resident #24 had pulled his table closer to him, crossed his arms on the table and laid his forehead down on his arms. I lifted up his head and arm and called out his name. He was unresponsive.

We (the other nurse, tech and I) moved him to his bed. I ran to the nurse's station to get the crash cart and called a code while they were arranging him. He had been tilted on his side and they were laying him flat. I returned to the room with the cart and I started compressions. Other nurse's were there by then placing the board under his back, putting on an oxygen mask and taking a blood pressure. He was not breathing, had no pulse or B/P (blood pressure). Someone took the oxygen mask off and started using a mask with ambu bag (a handheld device used to provide ventilation to people who are unable to breath). I was doing compressions when the policeman arrived. He (policeman) said, Let me help and took over compressions. I went to the desk to talk to 911 on the phone and get the paperwork ready. The other nurse stayed in the room. The policeman was here fast, within about five minutes."

F 281

### DEPARTMENT OF HEALTH AND HUMAN SERVICES NITEDO COD MEDICADE & MEDICAID SEDVICES

PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

	)   O( \ 1412 D( O) \ \ \ \ \ \	& MEDICVID SEVAICES				
STATEMENT OF BELLEVIOLE OF THE STATEMENT OF		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		TE SURVEY MPLETED	
		495102	B. WING _	·	08.	C /06/2015
	OVIDER OR SUPPLIER RE HEALTH SERV	ICES-ARLINGTON		STREET ADDRESS, CITY, STATE, ZIF 550 SOUTH CARLIN SPRINGS RC ARLINGTON, VA 22204		
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (E		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	

### F 281 Continued From page 24

This surveyor asked LPN #4 where she placed her hands on the resident while doing compressions. She demonstrated on herself, traced the ribcage, found the xyphoid process, placed her hands on top of the xyphoid process, partially on the upper abdomen and partially on the lower part of the sternum, then started mimicking compressions. For clarification I had LPN #4 demonstrate on me her hand placement during compressions. She repeated the above process identically. This surveyor drew a picture of a rib cage with xyphoid process and sternum and asked LPN #4 to show exactly where she would place her hands to do chest compressions. She traced out the ribcage with a pen and put a mark directly on the end of the xyphoid process (1). LPN #4 showed this surveyor her current CPR (BLS - basic life support) card. The card was issued on 08/30/13 and expires on 08/2015. The card had been issued from an American Heart Association course.

According to the American Heart Association, hand placement on an adult for chest compressions should be in the middle of the sternum. "...Imagine a line between the nipples and put your hands on the center of the chest right below that line. Push hard and fast--about two every second..." (1)

This surveyor received a copy of a blank "Personnel Folder Checklist Revised April 2014" from the DON at approximately 2:15 p.m. The checklist included an entry for "Job Specific Orientation Checklist (...Licensed Nurses...). The DON stated, "This is used by HR to check off for new employees." No such list was included in LPN #4's employee file. A copy of LPN #4's

F 281

Facility ID: VA0155

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

PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	,		0	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495102	B. WING			C 08/06/2015
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	
		OFO ADJUNCTON		550	SOUTH CARLIN SPRINGS ROAD **REV	ISED**
MANORU	CARE HEALTH SERVI	CES-ARLINGTON		AR	LINGTON, VA 22204	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 281	The transcript inclu- Mandatory: 2011 E Class Completed 1, this course stated, 'responding to emer presented. Resider weather emergenci evacuation proceduminutes Status: Casked if nurses are license and CPR cafacility. The DON's expectation that nur a current, valid CPF	was received by this surveyor. ded a notation, "Annual mergency Response Online /9/2012." Training details for "Description: Procedures for gency situations are not emergency situations, es, utility system failures and ares are addressed. 21 completed." The DON was expected to have a current and in order to work in the stated, "Yes, there is an arese will be licensed and have R card before working with not a policy stating this and it	F	281		
F 282 SS=D	The Administrator a were informed of the meeting with the supproximately 2:15 was received by the conference on 08/0 (1) American Hearthttp://www.heart.org (cardiopulmonary retails is a complaint 483.20(k)(3)(ii) SEF	t Association website: g, "Steps of CPR" esuscitation), 2014. deficiency. RVICES BY QUALIFIED	F2	282	F 282 Services by Qualified Persons/ plan.	per care
	The services provided by	led or arranged by the facility y qualified persons in ch resident's written plan of			The facility will continue to prarrange services that are proving qualified person in accordance	ided by

care.

each resident's written plan of care.

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		AND HUMAN SERVICES  & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495102	B. WING		C 08/06/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MANORO	CARE HEALTH SERV	ICES-ARLINGTON		550 SOUTH CARLIN SPRINGS ROAD **R ARLINGTON, VA 22204	EVISED**
(X4) ID PREFIX TAG	(EACH DEFICIENC)	N'EMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION
F 282	Continued From pa		F 2	1. Resident #17 care plan was re ensure that it included appropria	ate care
	by:	NT is not met as evidenced erview, facility document		strategies for the staff in the ever resistive behaviors occurred. Staff members #3 and #4 receiv	
	review, clinical reco failed to implement 17. The facility sta physically restraine	ord review, the facility staff the care plan for Resident # ff to follow the care plan and d the resident during		education on how to locate and appropriate care strategies for h behaviors.	andling
	skin tears to the re-	which resulted in bruising and sident's arms and hands.		<ol> <li>Patients with a behavior of re and/or resisting care have the p be affected.</li> <li>Review of current residents wh</li> </ol>	otential to o have a
	Findings included:			history of resisting or refusing ensure that their plan of care in	cludes
	11/18/12. Diagnos but were not limited	admitted to the facility on es for Resident # 17 included, it to: Alzheimer's disease, PVD		appropriate care strategies to gu staff should the behavior occur.	,
	pressure), depress	r disease), HTN (high blood ion, and muscle weakness.		<ol><li>Nursing staff will be educate staff development nurse on who the care strategies that should b</li></ol>	ere to find
	quarterly assessme	ADS assessment was a ent dated 05/19/15. This MDS ent with a cognitive score of		the behavior occurs, to provide patients as well as staff.	safety to
	in daily decision ma assessed the resid assistance with toil physical assist. Ad	esident had severe impairment aking skills. This MDS also ent as requiring extensive eting with at least one person ditionally this MDS assessed having behavior symptoms		Current residents that have beer as having a behavioral episode tracked on a behavior tracking labeled The behavior tracking logs will reviewed weekly in the morning	will be log. be g clinical
	and as 'not' resisting The most current for	g care.  Il MDS (minimum data set) rea assessment summary) was		meeting by the Interdisciplinary 90 days DCD/ADNS will do random w of staff members on different st	eekly audits

reviewed for comparison, dated 11/16/14. This

requiring extensive assistance from staff for

MDS assessed the resident with a cognitive score of "4", again indicating the resident had severe impairment in daily decision making skills and as

episodes.

confirm staff knowledge of where to find

care strategies to deal with behavioral

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000		= 0 MEDICAID CEDITOEO			,		AFFINOVED
		E & MEDICAID SERVICES_	Τ	· · - ·	· · · · · · · · · · · · · · · · · · ·		<u>. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	COM	TE SURVEY MPLETED
		495102	B. WING			i i	C / <b>06/2015</b>
NAME OF F	PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
431001	CARE HEALTH SERVI	TOPE ARI INICTOM		550	SOUTH CARLIN SPRINGS ROAD **REY	VISED**	
WANUKU	JARE MEALIN SERVI	ICES-ARLINGTON		ARI	LINGTON, VA 22204		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	Continued From pa	4 Identified concerns Will De TeVI			viewed b'	v	
		st one person physical assist.			4. Identified concerns will be rev the facility's QAA Committee.	It wow -	y
		sident was assessed as 'not mptoms and as 'not' resisting			Recommendations for further co	rrective	
	care. The resident	t triggered in the CAAS area of			action will be discussed and imp	lemented	i
	this MDS for: cogn	nition, communication, mood			as needed.		
	and urinary.				5. September 4, 2015		
	A review of a FRI (f	facility reported incident)			5. September 4, 2010		
	alleged that on 06/0	06/15, Resident # 17 sustained					
	three skin tears with	th bruising to the right wrist					
	during incontinence nursing assistants)	e care by two CNA (certified ), CNA # 3 and CNA # 4.					
		ord review on 08/05/15 and					
		otes were reviewed for					
	Resident # 17.						
		ed 06/06/15 and timed 8:32					•
		"Resident is alert and verbally at sustained skin tear on right					
	arm, during inconting	nence care trying to scratch					
	the CNA (certified n	nursing assistant), patent (sic)					
		e, kicking and scratching the ne writer to give skin care, slap					
		he face, also refused the					
	supervisor, son was	s put on the phone the patent					
		to him, MD (medical doctor) to apply triple antibiotic					
	ointment and cover						
		ed 06/06/15 and timed 11:32					
	her Rt (right) arm d	"Pt (patient) has bruises on lue to pt kicking and resisting					
	care this morning.	Area is red but not bleeding					
	noted (sic)Investi	gation done to find out cause.					
	Family requested in	ncident report written by the					

nurse on duty that time but it was not granted..."

A nursing note dated 06/06/16 and timed 11:48

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		AND HUMAN SERVICES			•	_		APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		LE CONSTRUCTION		СОМ	E SURVEY PLETED
		495102	B. WING				l	06/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
		OFO ADI MOTOM		!	550 SOUTH CARLIN SPRINGS	ROAD "REV	ISED**	
MANUR	CARE HEALTH SERVI	CES-ARLINGTON		1	ARLINGTON, VA 22204			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPI	BE	(XS) COMPLETION DATE
	completed, on asseright lower arm skir surrounding the ski (centimeters) X (by hand is noted with cof the arm. First arclosed discolored a that is on the left ou Second area measure red/purplish discothe left hand between Third area measure red/purplishclosed A nursing noted dat p.m. documented: sustained during All care3 skin tears to cm1cm X 2cmX	"Head to toe assessment was essment patient is noted with a tears, with bruising in tears that measures 14cm () 4.5cm. Left lower arm and discoloration in several areas ea measures 3cm X 2.5cm area that is purplish in colorater aspect of the arm. The ures 2cmX 2cmX closed that coloration that is on the back of en the thumb and index finger. The standard tears that was DL (activities of daily living) the right arm1.5 cm X 2 .0.3 cm X 1.2 cm"	F2	282		DY)		
	p.m., documented:	d 06/07/15 and timed 4:35 "Resident very combative g this shiftX-ray of right						
	care plan) was then the following: "As grooming, dressing sub-task for easier for flexibility in ADL mood, preferences, family input for best explain/reinforce ne	rent CCP (comprehensive reviewed and documented sist with daily hygiene,break ADL tasks into patient performanceAllow routine to accommodate and customary routineElicit approaches; ask physician to seed for treatmentIf resident to speak with resident and						

explain care in Spanish...if resists care, leave (if safe to do so) and return later...Do not invade personal space...Elicit family input for best

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

PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY IPLETED
		495102	B. WING				C (06/2015
NAME OF F	ROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				55	0 SOUTH CARLIN SPRINGS ROAD "REV	ISED**	
MANORO	CARE HEALTH SERVI	CES-ARLINGTON		A	RLINGTON, VA 22204		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	8E	(X5) COMPLETION DATE
F 282	Continued From pa	ae 29	FO	282			
1 202	•	vith in a low pitch, calm voice	1 2	.02	•		
	to decrease/elimins	ate undesired behaviorAllow					
		spond. Do not rush or supply					
		peak in calm, positive					
	/reassuring manner	Explain each activity/care					
	procedure prior to b	peginning itGain individual's					
	attention before beg	ginningProvide assistance					
	as neededprovide neededpsych con	e incontinence care as					•
	neededpsych con	isuit as neeceu					
	On 08/06/15 at app	roximately 8:00 a.m., the					
	assistant administra	ator was asked for the					
	investigation, abuse	e policy, along with the x-ray					
		ch consults regarding					
	Resident #17.						•
	The investigation si	ummary was presented and					
	reviewed. The inve	estigation was completed by					
	the DON (director of	of nursing) on 06/12/15. The					
	investigation summ	ary documented: "On					
	06/06/15 at approx	imately 5:30 a.m. (Resident #					
	17) sustained 3 sel	f inflicted skin tears to her right					
	arm during care (in	continence). The two staff patients hands while					
	attempting to perfor	rm incontinence careCNA#					
	3 attempted to prov	vide incontinence care and					
	Resident # 17 refus	sedCNA#3 and CNA#4					
		ontinence care for Resident#					j
	17Resident # 17	was yelling in another					
	language, kicked he	er feet and attempted to					
	explain that they we	NA#3, CNA#4 tried to					
	herResident # 17	continued to yell, kick and					
	tried to scratch CN	A#3, CNA#3 was holding					
	her hands so that s	he could not hit them while					,
	CNA#4 was chang	ging herConclusion: Based					
	on the investigation	including resident (other					İ
	residents in the fac	ility) and staff interviews it was use did not occur. The staff					
	determined that abi	use did flot occur. The stall				··	

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	} ` ·	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495102	B. WING		0:	C 8/06/2015
	PROVIDER OR SUPPLIER	ICES-ARLINGTON		STREET ADDRESS, CITY, STATE, ZII 550 SOUTH CARLIN SPRINGS RE ARLINGTON, VA 22204		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 282	care for the resident tears were accident resident's resistand not to intentionally. Employee stateme CNA # 3 (06/06/15 the room at 4 am to meshe was sittin wet with urine and linens while she war all over herself. I gshowed it to her ar She grabbed the dplaced it under her bedcovered herself asking her to saying no,told the me to go get the of mearound 5 am roomasked her to kept saying noW # 4 she told me to took a new depend your wet we are go 4 started to get the started to kick, hit, hands so she coulcholding her hand shand that's when I herselfCNA # 4 awe got the clothes dried stool all over legssaturated with a bed bath and wip upgot her dresses	ir best judgement in providing nt and the self inflicted skin tal and the staff reacted to the be to care. Their actions were		282		

PRINTED: 08/21/2015

		AND HOWAR GERVICES			_		HEEROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			-	1	0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
		495102	B. WING			08/0	) 06/2015
NAME OF P	ROVIDER OR SUPPLIER		1	STI	REET ADDRESS, CITY, STATE, ZIP CODE		
				550	SOUTH CARLIN SPRINGS ROAD **REV	/ISED**	
MANORO	ARE HEALTH SERVI	CES-ARLINGTON		AF	RLINGTON, VA 22204		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED OF THE	D BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 31	.F 2	282			
,		it the bathroom doorI went to	-				ı
	the nurse to tell her that the resident had a skin tear from changing her"						-
	care of Resident # was asked by CNA incontinence care for was already in the right. Resident # 17 understand. I tried needed to clean he movement and was changed. Resident kicked her feet and and bite her hands. and try to scratch CNA # 3 held her hands.	-"I was not assigned to take 17at approximately 5 a.mI # 3 to assist her with or Resident # 17CNA # 3 room when I came to assist was yelling words I could not to explain to her that we r. She was covered in bowel a really dirty and needed to be # 17 continued to yell out and was trying to scratch CNA # 3she continued to yell, kick actually scratched herself. So ands and I wiped herwhen ging her we say that her right"					
		Resident # 17 was reviewed egative for fracture or					:
	The psych consults the following:	were reviewed and revealed					
.•	aggression, psych refusals, stable on o is variable, episodic remeronstates sh with staff to discuss	Psychiatry Progress Note: nosiscombative with care, examstaff note that agitation is she was just started on e is content, mood goodmet is strategies for staff to manage edirect and distract"					

The facility's abuse policy documented: "...it is important to be familiar...definitions of abuse, neglect...Abuse can occur in many forms and to

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CENTER	DO EUD MEDICADE	& MEDICAID SERVICES			(	UJVORYYA MXO4
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MI II	TIDE	CONSTRUCTION	OMB NO. 0938-0391 (x3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	1		CONSTRUCTION	COMPLETED
		495102	B. WING			C 08/06/2015
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	
MANORO	CARE HEALTH SERV	CES-ARLINGTON			SOUTH CARLIN SPRINGS ROAD **RE LINGTON, VA 22204	VISED**
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F 282	Continued From pa	ge 32	F 2	282		
	slapping, pinching,	hysical abuse includes hitting, and kickingemployees are and annually on abuse				
	the assistant admin concerns regarding physically restraine and sustaining mult	DON (director of nursing), and istrator were informed of Resident # 17 being d during incontinence care iple skin tears and bruising, in survey team on 08/06/15 at 0 a.m.				
	judgement. The DO resident's CCP and issue with this resident alone and resident alone and resident's family for resident being restresident incurred phyphysically held dow DON was asked with documented in the	at the staff used their best DN was informed about the that this was an identified lent and the CCP was not nembers did not leave the did not attempt to contact the any guidance prior to the ained, and as a result the nysical injury from being n by the staff members. The last are/were the 'strategies', psych consult. The DON ining to what was in the				
	on the resident atte DON was informed statements of the si repeatedly told the si physical resistance members continued point of physical resi	riced that staff reacted based mpting to hit the staff. The that according to the staff members, the resident staff members no, prior to any from the resident and the staff I, provoking the resident to the sistance. Again, the DON was ding to the evidence the				

facility staff did not follow the resident's CCP for care resistance for Resident #17, and as result

PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			U	<u>INR NO: 0838-01</u>	<u> 397</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495102	B. WING			C 08/06/2015	<u>;                                    </u>
	ROVIDER OR SUPPLIER	ICES-ARLINGTON		550 SC	T ADDRESS, CITY, STATE, ZIP CODE DUTH CARLIN SPRINGS ROAD **REV NGTON, VA 22204	ISED**	
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F 314	provided or presen conference, to evid not physically restraincontinence care to comprehensive pla regarding the abov 483.25(c) TREATM PREVENT/HEAL F. Based on the compresident, the facility who enters the facility who enters the facility does not develop prindividual's clinical they were unavoidal pressure sores recompressed.	ion or documentation was ted prior to the exit lence that Resident # 17 was ained by staff during or that the resident's n of care was followed e issues and concerns. RENT/SVCS TO PRESSURE SORES or ehensive assessment of a must ensure that a resident lity without pressure sores are sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and	FS		F 314 Treatment/Services to prevent/heal pressure sores.  The facility will continue to pro treatments and services to prevheal pressure sores.  1. Resident #22 no longer resides facility.	ent or	
	by: Based on staff inte complaint investiga perform skin asses pressure sore for o survey sample. Fa documented skin a for twelve days folk facility. The reside Ill pressure ulcer o pressure sore deve	erview, clinical record and ation the facility staff failed to sements for the prevention of a one of 27 residents in the acility staff failed to provide assessments for Resident #22 owing a re-admission to the nt was then found with a stage in her coccyx (harm). The eloped necrotic tissue, a foul assed as a stage IV pressure	<i>;</i>		2. All residents at risk for pressur have the potential to be affected. facility will complete a skin swee residents. New identified pressur will be addressed. Comprehensiv pressure ulcer assessments, PUSF and Braden's will be completed accordingly; additionally care plabe updated to include prevention and individualized interventions a Physician/family will be notified, treatment orders obtained. Preve interventions will be validated.	The p on all re ulcers re I tools, ans will strategies and goals.	

sore prior to the resident's discharge from the

Facility ID: VA0155

facility.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	LETED
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
MANORO	CARE HEALTH SERVI	ICES-ARLINGTON		550 SOUTH CARLIN SPRINGS ROA ARLINGTON, VA 22204	AD **REVISED**	
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F 314	Continued From pa	5. New authostotis of feachinssion				
	The findings include	e:		have a skin check docume admission and a second sk documented within 24 hor	kin check	
	(NPUAP) defines a injury to the skin an over a bony promin or pressure in comb NPUAP defines a sthickness skin loss. visible but bone, ter exposed. Slough mobscure the depth of undermining and tu Category/Stage III panatomical location directly palpable." It pressure ulcer as, "exposed bone, tendeschar may be pressuredermining and turbone/muscle is visib NPUAP defines and as, "Full thickness to depth of the ulcer is slough (yellow, tan, eschar (tan, brown of Until enough slough to expose the base cannot be determined Category/Stage III of Resident #22 was a	ible or directly palpable." The unstageable pressure ulcer tissue loss in which actual s completely obscured by gray, green or brown) and/or or black) in the wound bed. In and/or eschar are removed of the wound, the true depth ned, but it will be either a or IV." (1)		The ADNS/Designee will reviews to validate compliance ordered. The ADNS/Desicomplete random reviews validate compliance, in the meeting.  4. Identified concerns will the facility's QAA Comming Recommendations for furt action will be discussed at as needed.  5. September 4, 2015	complete record iance, in the ng. Skin checks used nurses as ignee will of skin sheets to e daily QAA be reviewed by ittee.	
	discharged on 3/29/	on 2/23/15 and was 1/15. Diagnoses for Resident static endometrial cancer.				

hematuria, urinary obstruction, hyperpotassemia, thrombocytopenia, anemia, hypertension, diabetes, bronchopneumonia and urinary tract

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CENTERS FOR MEDICARE &	MEDICAID SERVICES			C	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	B. WING			C 08/06/2015
NAME OF PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	
MANORCARE HEALTH SERVICE	ES-ARLINGTON			SOUTH CARLIN SPRINGS ROAD **REV LINGTON, VA 22204	ISED**
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3/7/15 assessed Resi intact. This MDS ass require the extensive for transfers and bed  Resident #22's closed reviewed on 8/5/15. It is assessments for until 3/9/15 when the a stage III pressure so #22's treatment reconcompleted on 3/2/15 in assessment associated was at the hole on 3/4/15 for a blood if assessment was concreturn to the facility. Fresident was assesses sore to her coccyx. The resident's coccyx is pressure sore. Additing described the wound a presence of slough. In necrotic tissue, a foul assessed by a physiciate sore.  Resident #22's closed the resident was admit blanchable redness to the left 2/7/15. A readmission 2/23/15 listed the resident resident was admits.	um data set (MDS) dated ident #22 as cognitively sessed Resident #22 to assistance of one person mobility.  d clinical record was The record documented no Resident #22 from 2/24/15 resident was assessed with ore on her coccyx. Resident d indicated a body audit was but the record documented clated with this audit. The ospital for almost nine hours transfusion. No skin ducted upon the resident's Five days later (3/9/15) the d with the stage III pressure the record initially assessed wound as a stage III onal assessments as unstageable due to the The wound developed	F3	314		

catheter but no other areas of skin breakdown. A nursing note dated 2/24/15 stated, "...patient noted with her skin to be intact, no areas of

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	A - DE 115 4 1 7 1 1 DED\	OCC ADI INOTON		550	SOUTH CARLIN SPRINGS RO	)AD **REVISED**	•
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F 314	reducing mattress." by the facility as a lidevelopment with understanding Pressure Resident #22's Brad 3/9/15 documented 2/24/15 - Score of assessed with no siskin moisture, walk mobility, adequate a problem listed as "Finaximum assistant without sliding again."	Ishe is on a pressure Resident #22 was assessed ow risk for pressure sore se of the Braden Scale for a Sore Risk form.  den assessments prior to the following.  If (low risk) - Resident ensory impairment, occasional soccasionally, slightly limited nutrition with a friction/shear Requires moderate to be in moving. Complete lifting that sheets is impossible.	F	314			
	assessed with no soccasionally moist assisted into chair of mobility, adequate a problem listed as "Feebly or requires of move skin probably sheets, chairocca  The resident's plan listed the resident was to be at risk for skin entry dated 2/3/15 skin integrity related Interventions listed reposition as needed.	r (low risk) - Resident ensory impairment, skin, chairfast (must be or wheelchair), slightly limited nutrition with a friction/shear Potential problem: Moves ninimum assistance. During a slides to some extent against sionally slides down."  of care (print date 8/5/15) was assessed upon admission breakdown. The care plan stated, "At risk for alteration in to impaired mobility. were, "Encourage to ed; use assistive devices as ekin condition with ADL care					

daily, report abnormalities...Provide preventative

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AND DUAN OF CODDECTION DENTIFICATION AUGUSTO.		L (VO) A II I	TIO. C	CONCERNATION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILE		CONSTRUCTION	COMPLETED	
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NAME OF	NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
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F 314	Continued From pa	ge 37	F:	314			
	skin care routinely a than resolved entries heels upon admissi updates/revisions reprevention until the pressure sore on 3/3/15 and the pressure sore on 3/9/15 on her coccyx approinches width with noted during ADL (at this AM. Upon assenurse) manager of (III) wound to her co (centimeters) x 5 cm with scant amount of and 20% of epithelist cleaned with normal applied to wound be with Allevyn sacrum M.Dinformed of wheelchair cushion cushionHead to to is noted with bilatera suprapubic cath (cabilateral lower extremingairments noted of spends most of the	and prn (as needed)." Other as related to the resident's red on, there were no egarding pressure sore development of the coccyx 19/15.  Intend the resident was with a stage III pressure sore eximately 2 inches long and 2 depth listed. A nursing note in "Writer was notified by at patient had skin impairment activities of daily living) care essment with RN (registered 3rd floor patient with stage 3 accyx that measures 5 cm in with 80% slough present of serous drainage present all tissue present. Wound was I saline, pat dry, with Santyled, skin prep to periwound dressing applied to wound. Ound with treatment plan in for Santyl twice per day for e was changed to a Roho from a regular foam he assessment completed she all nephrostomy tubes, theter), coccyx wound, and mity pitting edema. No other during the assessmentShe time in her wheelchair during ter for ambulation transfers"					

documented, "Coccyx wound measure 5 cm x 5 cm with 80% slough present with scant amount of

serous drainage with 20% epithelial tissue

PRINTED: 08/21/2015

F 314 Continued From page 38  present. Periwound skin is intact with blanchable redness present." This record documented Resident #22's risk factors as resident required staff assistance to move, narcotic use, cancer/terminal illness, decreased sensory perception, newly admitted freadmitted and head of bed elevated most of the time. A note documented on this form stated, "Patient had appointmentfor recent blood transfusion on 3/4/15 she was picked upat 7:10 a.m. to be transported to hospital via stretcher. She arrived at hospitalat 8:06 am. She returned to facility at 4 pm on 3/4/15 via stretcher."  Additional nursing notes listed Resident #22's pressure sore as "unstageable" and with a foul odor. Pressure ulcer tracking records listed the wound developed necrotic tissue with heavy exudate and was later assessed by a physician as a stage IV pressure sore. The clinical record documented the following regarding the progress of Resident's coccyx pressure sore after 3/9/15.  3/10/15 - "Late entry for 3/9/15 for clarification. Wound is unstageable. Wound bed is 80% slough."  3/12/15 - Body audit done no new skin alteration noted continue with treatment on coccyx done as							FURM	APPROVED
AND PLAN OF CORRECTION  A BUILDING  B. WING  STREET ADDRESS. CITY. STATE, 2IP CODE  STREET ADDRESS. CITY. STATE, 2IP CODE  STREET ADDRESS. CITY. STATE, 2IP CODE  ARLINGTON, VA 22204  (X4) ID  SUMMARY STATEMENT OF DEFIDIENCIES PREFEX (EACH DEFIDIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)  F 314 Continued From page 38  present. Periwound skin is intact with blanchable redness present." This record documented Resident #22's risk factors as resident required staff assistance to move, narcotic use, cancer/terminal illness, decreased sensory perception, newly admitted/readmitted and head of bed elevated most of the time. A note documented on this form stated, "Patient had appointmentfor recent blood transfusion on 3/4/15 she was picked upat 7:10 a.m. to be transported to hospital via stretcher. She arrived at hospitalat 8:06 am. She returned to facility at 4 pm on 3/4/15 via stretcher."  Additional nursing notes listed Resident #22's pressure sore as "unstageable" and with a foul odor, Pressure ulcer tracking records listed the wound developed necrotic tissue with heavy exudate and was later assessed by a physician as a stage IV pressure sore as filer 3/9/15.  3/10/15 - "Late entry for 3/9/15 for clarification. Wound is unstageable. Wound bed is 80% slough."  3/12/15 - Body audit done no new skin alteration noted continue with treatment on coocyx done as	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO	<u>. 0938-0391</u>
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3/12/15 - Body audit done no new skin alteration noted continue with treatment on coccyx done as								
noted continue with treatment on coccyx done as			done no new skin alteration					į
ordered. "		noted continue with	treatment on coccyx done as					
		ordered"						
3/12/15 - "Body audit done no new skin								
alteration, continue with treatment on coccyx								
done as ordered well tolerated Pain management			Il tolerated Pain management					,
in progress"								
3/17/15 - "Patient followed up by wound team								
today, wound to her coccyx measures 3.5 cm x 6 cm with 80% slough present with moderate								

amount of serosanguineous drainage present and 20% of epithelial tissue present with edges macerated...braden score is a 17... Head to toe

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

CENTE	43 FUR MEDICARE	& MEDICAID SEKVICES				<u>OIAIR MÓ</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		CON	TE SURVEY MPLETED
		495102	B. WING				C /06/2015
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS,	, CITY, STATE, ZIP CODE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
			f	550 SOUTH CARL	IN SPRINGS ROAD **RE	VISED**	
MANORO	CARE HEALTH SERVI	CES-ARLINGTON		ARLINGTON, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CO	DER'S PLAN OF CORRECTI DRRECTIVE ACTION SHOU FERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314		ge 39 eted she is noted with bilateral , suprapubic cath, and	F3	14			,
	bilateral lower extre impairments noted 3/20/15 - "wound but no blood noted, new skin alteration 3/21/15 - "Body at alteration noted con 3/24/15 - "patient fo	mity pitting edema. No other during the assessment" care done it have drainage it is very hard to touchno					
	10.5 cm x 2 cm dep (tunneling) at 6 o'cld with heavy amount or present edges macrodor present. Wour saline, pat dry, with skin prep to periwoudressing applied to assessment comple	th with 3.5 cm tunnelling ock with 100% slough present of serosanguineous drainage erated, wound noted with foul and was cleaned with Dakins Santyl applied to wound bed, and with Allevyn Sacrum wound. Head to toe eted during wound round with oted to her bilateral lower					i prije di summa njema nje
	the coccyx wound diassessments according	sure ulcer healing chart for ocumented the following ding to the pressure ulcer JSH) scoring system.					·
	exudate, length x wi 3/17/15 - necrotic tis exudate, length x wi 3/24/15 - slough pre	ent with light amount of dth > 24.0 square cm sue with moderate amount of dth > 24.0 square cm sent with heavy amount of dth > 24.0 square cm	,	·			
	documented the res	ss note dated 3/17/15 ident had an unstageable area with instructions to		·			

apply a Santyl wet to dry dressing daily. A

PRINTED: 08/21/2015

DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES				FORM	M APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					D. 0938-0391
A BUILDING  495102  NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-ARLINGTON  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314  Continued From page 40  physician's progress note dated 3/25/15 stated, "Internal Medicine Follow-upStage IV large coccyx ulcer: Patient is wheelchair bound with extensive medical hx (history) with advanced Endometrial CA (cancer) - now has a large sacral pressure wound of difficult management due to lack of mobility and nutritional deficits" An undated addendum to this note stated, "Pt (patient) very weak at extreme risk for breakdown at any site. Her coccygeal area decubiti was preempted by poor muscle conditionand nine hours of being on a stretcher/gurney while at (hospital) ED (emergency department)"		1 '		E CONSTRUCTION		TE SURVEY	
		i		UZ	C 3/06/2015		
NAME OF F	PROVIDER OR SUPPLIER	L		s	TREET ADDRESS, CITY, STATE, ZIP CODE		0,00,2013
MANOR	CARE HEALTH SERV	ICES-ARLINGTON		1	50 SOUTH CARLIN SPRINGS ROAD **RE .RLINGTON, VA 22204	:VISED**	
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 31/	Continued From an	on 40		24.4			
1.214		•	F3	514			
					•		
	(hospital) ED (emer	gency department)"					
		ented the resident was out of					
		oital on 3/4/15 from 7:10 a.m.					
		ng a blood transfusion. There skin assessment upon the					
		m the blood transfusion on			•		
		d 3/4/15 at 7:26 p.m. listed an					
		resident's vital signs and					
		ut included no assessment of					
		documented, "Patient as alert					
		turned from blood transfusion					
	•	ndition, no reaction noted at					
	this time. All pm an administered as ord	lered well tolerated. One staff					
		and transferred to bed"					
		/9/15 the resident was					
		tage III pressure sore to her			,		ļ
	coccyx.				·		
		nted a physician's order dated					

Monday for "skin observation." After the

readmission assessment dated 2/23/15 there was no further mention of the resident's skin until 3/9/15 when the resident was assessed with

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		A MEDIONE OFFICE					TAPPROVED
		& MEDICAID SERVICES	<del></del>				<u>. 0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILE		E CONSTRUCTION	COV	TE SURVEY MPLETED	
		495102	B. WING	·		1	C /06/2015
NAME OF	PROVIDER OR SUPPLIER			S7	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-ARLINGTON			50 SOUTH CARLIN SPRINGS ROAD **REV RLINGTON, VA 22204	/ISED**	:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Continued From pa	-	F:	314			
	signed off the reside 3/2/15 indicating a lathere was no document the record. Skin certified nurses' aid 3/2/15 and 3/5/15 in was "Abnormal." To sheet's body diagral lower back area. To Abnormal if: broken There were no nurse either of these skin describing the abnormal on 8/6/15 at 8:25 a	lcer on her coccyx. A nurse ent's treatment record on cody audit was completed but mentation of this assessment worksheets completed by the es during ADL care dated lentified the resident's skin wo areas were marked on the m on the resident's right/left he form stated, "Check n, bruised or reddened areas." ing assessments regarding worksheets identifying or rmal skin areas.  .m. the licensed practical cared for Resident #22					
	during her stay was assessments. LPN remember Resident assessments, LPN assessments were residents. LPN #4 swrong you report to note." Concerning any impairment, LPI note everything is onurses' aide (CNAs each resident on shwere any problem swere reviewed by the On 8/6/15 at 8:30 a. Resident #22's nurs stay was Interviewed	interviewed about skin #4 stated she did not #22. Concerning skin #4 stated weekly skin supposed to be done on all stated, "If you see anything wound team and make a skin assessments not showing N #4 stated, "You make a k." LPN #4 stated certified of filled out "shower sheets" for ower days indicating if there kin areas and these sheets					

don't remember."

skin. CNA #2 stated, "Too many residents. I

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		AND HUMAN SERVICES				FOR	MAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		LE CONSTRUCTION		ATE SURVEY OMPLETED	
							С
		495102	B. WING			0	8/06/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	CES-ARLINGTON		1	550 SOUTH CARLIN SPRINGS ROAD **F	EVISED**	
MARCIN	SAILE HEACHT GETT			- 1	ARLINGTON, VA 22204		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 42	F;	314			•
		.m. the director of nursing					
		wed about any skin			·		
		days prior to Resident #22's re. When asked if she had					
		nts for Resident #22 between					
		, the DON stated, "No. We do					
		ted they conducted an					
		ne pressure sore was found					
		N stated the outcome of their eresident had lots of					
		spent a long time on a					
		ne hospital on 3/4/15 for the					
		The DON stated nurses did					
		assessment when the resident					
		ospital on 3/4/15 until the					
	report of the pressu	ire ulcer on 3/9/15. The DON					
		nents were routinely done on facility but they did not					
		#22's day at the hospital for			,		ł
		on a readmission. The DON					
		s of skin impairment on the					ĺ
		ited 3/2/15 and 3/5/15 were					
		nt's nephrostomy tubes. The					
		nt any nursing assessments shower sheets showing an			•		•
		ring these areas as the					
	nephrostomy tubes	. When asked what could			,		
	have been done in	attempt to prevent/minimize					j
	Resident #22's pres	ssure sore, the DON stated,					
	"Assessment before	e and after she (Resident #22)					
•	went out."						

On 8/6/15 at 10:55 a.m. the licensed practical nurse (LPN #3) unit manager was interviewed about Resident #22. LPN #3 stated if skin impairments were found an incident sheet was completed, the physician was contacted for treatment orders and the wound was then tracked weekly by the wound team. When asked if

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		. 495102	B. WING		C 08/06/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	ICES-ARLINGTON		550 SOUTH CARLIN SPRINGS ROAD **REVI ARLINGTON, VA 22204	SED**	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  X (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)	BE COMPLETION	
F 314	appearance, preser #3 stated, "We are stated nurses initial indicating a skin as not make notes reg unless there was in treatment record ini LPN #3 did not pres documented skin as 3/9/15 when the preserved in the Prevention and Ulcers: Quick Refe 16 states, "Skin and important in pressur classification, diagn health professionals comprehensive skir techniques for ident localized heat, eden individuals at risk of comprehensive skir	ments included a ment of the skin (color, noce of pain or moisture), LPN not doing that." LPN #3 ed the treatment records sessment was done but did arding the assessments apairment. Other than the itialed by a nurse on 3/2/15, sent any evidence of a sessment from 2/24/15 until essure sore was found.  Treatment of Pressure rence Guide on pages 15 and it issue assessment is	F3	14		

part of every risk assessment, ongoing based on the clinical setting and the individual's degree of

discharge...Increase the frequency of skin assessment in response to any deterioration in overall condition...Document the findings of all comprehensive skin assessments...Ongoing assessment of the skin is necessary in order to detect early signs of pressure damage, especially over bony prominences...Include the following factors in every skin assessment: skin temperature; edema; and change in tissue consistency in relation to surrounding

tissue...Assess localized pain as part of every

risk and prior to the individual's

### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/21/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING \_ 495102 С 8. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 08/06/2015 MANORCARE HEALTH SERVICES-ARLINGTON 550 SOUTH CARLIN SPRINGS ROAD \*\*REVISED\*\* ARLINGTON, VA 22204 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL in PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG **PREFIX** (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 314 Continued From page 44 F 314 skin assessment. When the individual is able to respond reliably, ask him or her to identify any areas of discomfort or pain that could be attributed to pressure damage..." (2) These findings were reviewed with the administrator, director of nursing and assistant administrator during a review meeting on 8/6/15 al 9:50 a.m. This was a complaint deficiency. (1) NPUAP Pressure Ulcer Stages/Categories. National Pressure Ulcer Advisory Panel. 8/8/15. <a href="http://www.npuap.org/resources/educational-and">http://www.npuap.org/resources/educational-and</a> -clinical-resources/npuap-pressure-ulcer-stagesc ategories/> (2) National Pressure Ulcer Advisory Panel. European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Perth, Australia: 2014. Free of medication error rates of 5% or F 332 483.25(m)(1) FREE OF MEDICATION ERROR more. F 332 SS=D RATES OF 5% OR MORE The facility will continue to ensure that The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:

Based on medication pass and pour observation, staff interview and clinical record review the facility staff failed to ensure a medication error

it is free of medication error rates of five

percent or greater. 1. Resident #16 was assessed for adverse

effects, medication error report completed, and her physician and responsible party was notified.

LPN #2 completed medication pass training.

Additional training was provided to the LPN that failed to transcribe the order.

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

Event ID: ROJU11

Facility ID: VA0155

if continuation sheet Page 45 of 47

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CENTI	ERS FOR MEDICARE	& MEDICAID SERVICES			PRINTED: 08/21/20 FORM APPROVE	
CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION	OMB NO. 0938-03		
		DENTIFICATION NUMBER:	A. BUILDI	NG	(X3) DATE SURVEY COMPLETED	
		495102	B. WING		С	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/06/2015	
MANORCARE HEALTH SERVICES-ARLINGTON			550 SOUTH CARLIN SPRINGS ROAD **F ARLINGTON, VA 22204	REVISED**		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRES	(43)	
F 332	Continued From page	ne 45				
	rate of less than five	(5) percent. There were two	F 33			
	errors out of twenty-	SIX Opportunities resulting in		<ol><li>All residents have the poten affected.</li></ol>	tial to be	
	an error rate of 7.69	%.		Orders for currents were revie	1.	
	Find near thinks to			ensure that medications ordere	wed to	
	Findings include:			noted and entered into the syst	em correctly	
	A medication pass a	nd pour observation was			-	
	conducted 8/5/15 be	ginning at 8:15 a m. with		<ol><li>Nurses completed medicatio training.</li></ol>	n pass	
	prepared medication	cal nurse) # 2. LPN # 2		New orders will be reviewed by	41.	
	surveyor recorded ma	s for Resident # 16 as this edication name and dose		Administrative Director of	y tne	
	from the label on the	medication card. Included		Nursing/Director of Care Deliv	ery to	
	III Nesident # 16's me	edications was "Abilify 2		ensure that orders are transcribe	ed correctly	
	ranger GIAR \ Wd OLS!	V one time a day for		into the electronic system for 9	n days	
	debiession GIVE MI	H 5 MG = 7 MG " and		Nurses will receive medication	nass	
	day for depression G	ve 5 mg orally one time a VE WITH 2 MG = 7 MG."		training on hire, annually, and a	s .	
	The resident's medica	Stions also included "Vitamia		appropriate, should there issues	be noted.	
	D-12 (ablet 1000 mcc	l Give one sublingually		4. Identified concerns will be re		
,	under the tongue) on	e time a day" I PN # 2 thon		the facility's QAA Committee.	viewed by	
•	adiministrated Residen	I# 16's medications		Recommendations for further co	prootive	
r	vesineur# 10 (00K SII	medications whole, by		action will be discussed and imp	lemented	
,	inglinated to blace	water. The resident was the Vitamin B-12 tablet		as needed.	remented	
ŭ	inder her tongue.			5. September 4, 2015		
T	he clinical record was	reviewed 8/5/15 at 8:35		. , , , , <del>, , , , , , , , , , , , , , ,</del>	ļ	
a	.m. for reconciliation (	of medications				
a a	aministered. A physic	ian order dated 8/4/15			1	
u	recied Decrease Abi	lity to 5 main or (by mouth)			ļ	
ia la	very day." The order on the order of the ord	was signed by the			ł	
W	ritten on the order.	ted with staff initials				
Oı	າ 8/5/15 at 8:50 a m. ເ	PN # 2 was interviewed			1	
ao	out the two medicatio	DS. J.PN # 2 stated "The				
عاد	aff member who 'noted	d' the order was				

CENTE	RS FOR MEDICARI	AND HUMAN SERVICES  & MEDICAID SERVICES			F	NTED: 08/21/201 FORM APPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LTIPLE CONSTRUCTION	OME	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		495102	B. WING			C	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-ARLINGTON				STREET ADDRESS, CITY, ST. 550 SOUTH CARLIN SPRIN ARLINGTON, VA 22204	NGS ROAD **REVISE	08/06/2015 D**	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	(X5) COMPLETION FE DATE	
F 332	7 mg dose." LPN # administration of the 2 stated "Maybe I w usually give it to her The administrator, a DON (director of nurabove findings durin 8/5/15 at 3:30 p.m.	ng the two tablets to equal the 2 was then asked about the 2 Vitamin B-12 tablet. LPN # as just carried away!	F3	32			