ManorCare Arlington
550 S. Carlin Springs Road
Arlington, Virginia 22204
703.379.7200
703.820.0102 fax

ManorCare Health Services

October 19, 2017

Paul Wade, LTC Supervisor Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive, Suite 401
Richmond, VA 23233

RE: Manorcare Health Services-Arlington
Provider Number 495102

Dear Mr. Wade:

Enclosed herein is our Plan of Correction (CMS-2567) for the unannounced standard survey and biannual State Licensure inspection that was conducted 10/03/2017 through 10/04/2017. The corrections for the State Licensure have been cross referenced to the F-Tag corrections.

I hope you will accept our plans with favorable considerations.

Yours Sincerely,

Ibrahim Kamara, Administrator

PRINTED: 10/17/2017
FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	A. BUILDING _____ B. WING _____	10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 10/03/2017 through 10/04/2017. Corrections are required for compliance with Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 161 certified bed facility was 120 at the time of the inspection. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and three (3) closed record reviews (Residents #22 through #24).	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12VAC5-371-250 (G). Please cross reference to F-279. 12VAC5-371-260 (C). Please cross reference to F-518.	F 001	12VAC5-371-250 (G) has been cross referenced to F-279 12VACC5-371-260 (C) has been cross referenced to F-518	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	10/19/2017

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

PRINTED: 10/17/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	A. BUILDING _____ B. WING _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/03/2017 through 10/04/2017. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. The census in this 161 certified bed facility was 120 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and three (3) closed record reviews (Residents #22 through #24).	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 279	The following plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. **F 279 Develop Comprehensive Care Plans** It is the practice of this facility to develop person-centered plans of care that include non-pharmacological interventions	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ADMINISTRATOR (X6) DATE: 10/19/2017

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

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

PRINTED: 10/17/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	A. BUILDING _____ B. WING _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident	F 279	to address pain control for its residents with pain. **I** **Corrective action** Resident #17 no longer resides in the facility, but the practice has the potential to affect other residents in the facility. **II** **Identification of other residents** Other residents in the facility have the potential to be affected by the deficient practice. The Director of Nursing or designee has completed a review of care plans related to pain of residents that currently reside in the facility and updated care plans that require non-pharmacological interventions.	

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

PRINTED: 10/17/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	A. BUILDING _____ B. WING _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 interview, and staff interview, the facility staff failed for one of 24 residents in the survey sample (Resident # 17) to develop a plan of care that included non-pharmacological interventions to address pain control for the resident. The findings were: Resident # 17 in the survey sample, a 75 year-old male, was admitted to the facility on 6/8/16, and most recently readmitted on 9/22/17 with diagnoses that included rheumatoid arthritis, gastroesophageal reflux disease, anemia, rheumatoid lung disease, hypertension, peripheral vascular disease, chronic obstructive pulmonary disease, status post right below the knee amputation, and sleep apnea. According to the most recent Minimum Data Set, with an Assessment Reference Date of 9/29/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 14 out of 15. According to Resident # 17's electronic clinical record, he takes two medications, Oxycodone 5 mg (milligrams) and Tylenol 325 mg, on an as needed basis for pain control. At 8:45 a.m. on 10/4/17, the resident was interviewed regarding his pain control. Resident # 17 said he has "...a chest tube that drains fluid off my lungs that is a little tender, phantom pain on my right stump, and arthritis pain in my wrists and hands." The resident also acknowledge his use of pain medications as needed. Asked about non-pharmacological interventions to address his pain, such as warm compresses, bio-feed back, or other diversions, the resident said, "They have never offered any other pain relief options."	F 279	**III** **Systemic Changes** The Unit Managers and members of the interdisciplinary team (IDT) would be re-educated on the proper completion of person-centered care plan for residents, especially as it relates to pain, to include non-pharmacological interventions. **IV** **Monitoring** The Director of Nursing or designee would audit care plans addressing pain weekly for four weeks and once a month for two months to ensure compliance. **V** **Date of Compliance** **11/07/2017**	

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

PRINTED: 10/17/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	A. BUILDING _____ B. WING _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3 Review of the resident's care plan revealed two problems in the area of pain. The first problem, dated 8/2/17, was, "Pain related to right lower extremity amputation." The goal for the problem was, "Will express that pain management is within acceptable limits." The interventions for the stated problem were, "Administer pain medication per physician orders; Encourage/Assist to reposition frequently to position of comfort; and, Notify physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective." The second problem, dated 9/25/17, was, "At risk for pain related to recent surgery." The goal for the second problem was, "Reduce episodes of breakthrough pain." The interventions for the stated problem were, "Administer pain medication per physician orders; Encourage/Assist to reposition frequently to position of comfort; and, Notify physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective." The findings were discussed during a meeting at 9:45 a.m. on 10/4/17 that included the facility Administrator, Director of Nursing, and the survey team.	F 279	**F 518 Train All Staff-Emergency Procedure** It is the practice of this facility to train its employees in emergency procedures upon hire, and periodically review the procedures with existing staff. The facility also carries out unannounced staff drills to ensure staff members are knowledgeable of emergency procedures, including power outage and fire emergencies.	
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced	F 518	**I** **Corrective Action** CNA #1 has been re-educated and demonstrates competency and knowledge of emergency	

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

PRINTED: 10/17/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	A. BUILDING _____ B. WING _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 518	Continued From page 4 by: Based on staff interview and facility document review, the facility failed to ensure staff members were knowledgeable of emergency procedures. One of 8 employees interviewed were not familiar with protocols for power outage and/or fire emergencies. The findings include: On 10/03/17 at approximately 11:15 p.m., the facility was contacted by telephone to conduct interviews regarding abuse policies and emergency preparedness. CNA (Certified nursing assistant) #1 was interviewed about her role if there was a fire or power outage. CNA #1 stated that she was hired on 08/10/2017 and had not worked at the facility very long. She was asked if she had received training during orientation regarding power outages and fires. She stated that she "probably did", but she had "gone over a lot of information at the time of her hire. CNA #1 was asked if she knew whether or not the facility had a generator. She stated, "I think we do." She was asked if she know how long it took the generator to come on in the event of a power outage, or what all was functional on generator power. She stated, "I don't know." CNA #1 was asked if she knew what to do to ensure that beds were operational during a power outage. She stated, "I think there is a switch or something on them to make them work." She was asked if anyone had talked to her about special plugs or red outlets. She stated, "I don't know... I wasn't prepared to talk to you." CNA #1 was asked about fire drills. She stated	F 518	procedures, including power outage and fire emergency. **II** **Identification** Residents who reside in this facility have the potential to be affected by this deficient practice. The existing staff and potential new staff have the potential to be deficient on the emergency, including power outage and fire emergencies. **III** **Systemic Change** The Administrator or designee will reeducate the facility staff on emergency procedures, including protocols for power outage and fire emergencies. **IV** **Monitoring**	

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

PRINTED: 10/17/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	A. BUILDING _____ B. WING _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 518	Continued From page 5 that she had not participated in a fire drill. She was asked if she knew what her role was. She stated, "I guess get the residents safe." She was asked if there was a system in place to tell her where a fire was located. She stated, "I guess we look for the smoke." She then started talking to someone passing by in the hallway. She was heard to say, "Hey [name]. Did you just get here?" CNA #1 then stated to this surveyor, "I already told you I don't know... I haven't worked here very long." Training records for CNA #1 were reviewed with the employee files. Records documented CNA #1 completed training on 08/10/2017 regarding emergency preparedness. On 10/04/17 at 8:10 a.m. the maintenance director was interviewed. He stated that during employee orientation he educated staff regarding the generator, emergency preparedness, power outages and fire protocol. He stated the timing for the generator to come on, the red plugs, what to do in a fire, all were reviewed. The DON (director of nursing) and the administrator were notified of the above information during an end of the day meeting on 10/04/2017. No further information was obtained prior to the exit conference on 10/04/2017.	F 518	The Administrator or designee will train employees upon hire on emergency procedures, including the protocols for power outage and fire safety. The Administrator or designee will also carry out unannounced staff drills every month yearly to ensure staff competency on the emergency procedure, including protocols for power outage and fire emergencies. V **Date of Compliance** **11/07/2017**	