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 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED 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 Abbreviated Survey was conducted 09/09/19 through 09/11/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 161 certified bed facility was 139 at the time of the survey. The survey sample consisted of four current resident reviews (Resident #2, #3, #4 and #6) and two closed record review (Resident #1 and #5).	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 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657	**F657 Care Plan Timing and Revision** It is the practice of the facility to review and revise the comprehensive care plan. **I. Corrective Action** Resident #3 care plan was reviewed and revised to reflect Head of bed elevated per physician's order. **II. Identification** All residents with orders to have head of bed elevated have the potential to be affected by this practice. The Director of nursing/designee will conduct an audit of all current residents to identify residents who have orders to elevate head of bed to ensure that they have appropriate care plans and the Kardex is reflective. **III. Systemic Changes** The Director of Nursing/designee will provide education to licensed nurses on revision of care plans to reflect person centered care	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/2/19

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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F 657	Continued From page 1 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the CCP (Comprehensive Care Plan) for gastrostomy peg tube care and maintenance, for two of 6 residents in the survey sample, Resident #3 and Resident #1. Findings include: 1. Resident #3 was originally admitted to the facility on 08/05/10. The most current readmission was on 07/20/19. Diagnoses for Resident #3 included, but were not limited to: anoxic brain injury/damage resulting in a persistent vegetative state, peg tube, aphasia, anemia, high blood pressure, history of seizure disorder, DM (diabetes mellitus-uncomplicated), tracheostomy with continuous oxygen use, and intermittent asthma. The most current full MDS (minimum data set) was an annual assessment dated 08/06/19. This MDS assessed the resident as being in a persistent vegetative state, totally dependent upon staff for all ADLs (activities of daily living). The resident was assessed as having a feeding tube and receiving 51% or more of total calories from the peg tube and 501 cc (cubic centimeters) or more of fluid intake per day from the feeding tube. The resident triggered in the CAAS (care area assessment summary) section of this MDS for nutrition, feeding tube, and dehydration.	F 657	**IV. Monitoring** The Director of Nursing/ designee will complete audits of 2 residents with orders to elevate head of bed weekly for 4 weeks and monthly for 2 months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **Date of Compliance** **10/25/19**	

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F 657	Continued From page 2 A complaint investigation was conducted on 09/09/19 through 09/11/19, with allegations related to peg tube feeding and care. During the clinical record review, Resident #3's physician's orders were reviewed and included orders for: "...enteral feed...every shift continuous...60ml (milliliters)/hr (hour) Start at 1600 and run until 1000 mls has infused...flush with water 250 ml every 6 hours...flush with 30 ml of water before and after each feed...flush...with 5 ml of water after each medication...HOB (Head of Bed) elevated to 45 degree every shift for Aspiration Precaution..." The resident's kardex was reviewed and did not document anything regarding the resident's peg tube or care thereof. The resident's current CCP (comprehensive care plan) was reviewed and documented, "...administer tube feeding regimen and medication per physician's orders...report changes related to signs of fluid deficit...fluid overload...feeding tube/potential for complications of feeding tube related to aspiration potential/swallowing impairment...administer TF (tube feeding) formula, hydration...per order...observe for and report any signs of aspiration or intolerance of feeding...provide hygiene...speech therapy evaluation and treatment as ordered..." No interventions were found to keep the resident's head of bed at a 45 degree per the physician's order to assist with prevention of aspiration. No interventions were found to prevent the potential for aspiration pneumonia	F 657		

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F 657	Continued From page 3 (i.e. keep HOB elevated while TF is infusing and/or hold TF when resident is reclined). On 09/10/19 at 5:00 PM, RN (Registered Nurse) #3 was interviewed regarding the physician's order for Resident #3 to keep the HOB up at a 45 degree angle and that the resident's CCP did not reflect that. RN #3 stated that the resident's care plan should have included the intervention to keep the head of bed up, as ordered by the physician. RN #3 stated that the HOB should still be up at least 30 degrees for residents with tube feeding and included in the resident's care plan, even if there isn't an order to do so. RN #3 stated that is part of the care for a peg tube. On 09/10/19 at 5:30 PM, the administrator, DON (director of nursing) and LPN #1 were made aware of the above information in meeting with the survey team. No further information and/or documentation was presented prior to the exit conference on 09/11/19 at 12:15 PM, to evidence that Resident #3's CCP had been reviewed and revised to include the physician's order and/or actual interventions to implement for the prevention of aspiration pneumonia for a resident with a peg tube. 2. Resident #1 was originally admitted to the facility on 09/10/18, with the most current readmission on 04/24/19. Diagnoses for Resident #1 included, but were not limited to: vascular dementia, high blood pressure, DM (diabetes mellitus), dysphagia, chronic blood clots, chronic kidney disease-stage 3, history of a stoke with left side hemiparesis and gastrostomy tube.	F 657		

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F 657	Continued From page 4 The resident's most recent full MDS was a significant change assessment, dated 05/01/19. This MDS assessed the resident as having short and long term memory impairment, with severe impairment in daily decision making skills. The resident was also assessed as requiring total assistance from staff for all ADL's. The resident was assessed as having a feeding tube and receiving 51% or more of the total calories from the peg tube and 501 cc (cubic centimeters) or more of fluid intake per day from the feeding tube. The resident triggered in the CAAS (care area assessment summary) section of this MDS for nutrition, feeding tube, and dehydration. During a complaint investigation on 09/09/19 through 09/11/19, an allegation within the complaint alleged that the facility staff failed to follow physician's order for Resident #1 regarding keeping the HOB elevated when the tube feeding was infusing. Resident #1's admission order from 04/24/19 were reviewed and included an order for, but not limited to: "...enteral feed order...if gastric residual volume greater than 400...flush enteral tube every shift with 30 mls water before and after med pass...Glucerna 1.2...60 ml/hr...run until 1250 mls has infused...flush with water...150 ml every 4 hours...pleasure feeding thin liquids puree solids..." No physician's orders were found regarding keeping the HOB elevated, no other care and maintenance orders were found for this resident's peg tube. The resident's current CCP was then reviewed (admission 04/24/19 through discharge 05/12/19).	F 657		

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F 657	Continued From page 5 The CCP documented, "... administer tube feeding formula, hydration...per order...provide oral care...report signs of aspiration or intolerance of feeding...speech therapy evaluation..." No interventions were found on the CCP to prevent aspiration risk in a resident with a peg tube. On 09/10/19 at 5:00 PM, RN (Registered Nurse) #3 was interviewed regarding the residents with peg tubes. RN #3 stated that the HOB should still be up at least 30 degrees for resident's with tube feeding and included in the resident's care plan, even if there isn't an order to do so. RN #3 stated that is part of the care for a peg tube. On 09/10/19 at 5:30 PM, the administrator, DON (director of nursing) and LPN #1 were made aware of the above concerns in a meeting with the survey team. No further information and/or documentation was presented prior to the exit conference on 09/11/19 at 12:15 PM, to evidence that Resident #1's CCP had been reviewed and revised to include actual interventions to implement for the prevention of aspiration pneumonia for a resident with a peg tube. This is a complaint deficiency.	F 657	**F693 Tube feeding management** It is the practice of the facility to follow physician's orders for peg tubes. **I. Corrective Action** Resident #3 peg tube pump was set to 250ml/hr per physician's order. **II. Identification** All residents with orders for a peg tube have the potential to be affected by this practice. The Director of nursing/designee will conduct an audit of all current residents to identify residents for a peg tube to ensure that they are set at the amount. **III. Systemic Changes** The Director of Nursing/designee will provide education to licensed nurses following physician's orders. **IV. Monitoring** The Director of Nursing/ designee will complete audits of 2 residents with peg tube orders weekly for 4 weeks and monthly for 2 months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **Date of Compliance** **10/25/19**	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 693		

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F 693	Continued From page 6 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure a physician's order for a tube feeding flush of gastrostomy (peg) tube was followed for one of 6 residents in the survey sample, Resident #3. Findings include: Resident #3 was originally admitted to the facility on 08/05/10, with the most current readmission was on 07/22/19. Diagnoses for Resident #3 included, but were not limited to: anoxic brain injury/damage resulting in a persistent vegetative state, gastrostomy (peg) tube, aphasia, anemia, high blood pressure, tracheostomy with continuous oxygen use, and intermittent asthma. The most current full MDS (minimum data set) was an annual assessment dated 08/06/19. This	F 693		

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F 693	Continued From page 7 MDS documented the resident as being in a persistent vegetative state. The resident was assessed on this MDS as having a feeding tube. The resident received 51% or more of the daily calories and fluid intake from the feeding tube. On 09/09/19 at 4:30 PM, Resident #3 was observed in her room, laying in bed with TF (tube feed) running. The TF machine displayed the settings for the feeding and water flush. The TF machine read that the TF was set at a rate 60 ml/hr (milliliters per hour) and a water flush of 200 ml (milliliters) every 6 hours. The resident's physician's orders were reviewed and documented, "...(Order dated: 07/24/19 Start date: 07/24/19) Enteral feed order every shift continuous Enteral feeding: Jevity 1.2 Rate: 60 ml/hr; Start at 1600 (4pm) and run until 1000 mls has infused; Tube Type: G-tube; Size of tube...Flush with water 250 ml every 6 hours. Monitor Q (every) shift..." The resident's CCP (comprehensive care plan) was reviewed and documented, "...Report changes r/t [related to] signs of fluid overload...Date Initiated: 07/22/2019...Report changes r/t signs of fluid deficit (tongue furrows, dry mouth, etc.)...Administer tube feeding formula, hydration and flushes per order Date Initiated: 01/28/2011..." Resident #3 was again observed on 09/10/19 at 7:45 AM. The resident was laying in bed with TF (tube feed) infusing. The TF machine displayed the settings listed that the resident was receiving the prescribed TF at a rate 60 ml/hr (milliliters per hour) and a water flush of 200 ml (milliliters) every 6 hours.	F 693		

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F 693	Continued From page 8 The resident was again observed at 9:40 AM. Resident #3 was laying in bed with TF (tube feed) infusing. The TF machine displayed the settings listed that the resident was receiving the prescribed TF at a rate of 60 ml/hr (milliliters per hour) and was to receive a water flush of 200 ml (milliliters) every 6 hours. Resident #3 was again observed on 09/10/19 at 1:15 PM. Resident #3's TF infusion was complete and not infusing. On 09/10/19 at 5:10 PM Resident #3 was again observed. Resident #3 was sitting in her room in her wheelchair with the TF infusing. The TF machine displayed the infusing settings, which were [flow rate] 60 ml/hr (milliliters per hour) and a water flush of 200 ml (milliliters) every 6 hours. At approximately 5:15 PM, RN (Registered Nurse) #3 was asked to explain the resident's TF machine settings. RN #3 stated that the rate is 60 ml/hr and the water flush is 200 ml/hr. RN #3 was then asked to look at the resident's physician's orders. RN #3 stated that she did not know why the resident's TF machine flush setting was not set to the correct amount and was not sure how long the water flush had been set to 200 ml (every 6 hours), but confirmed that Resident #3 was ordered 250 ml flush every 6 hours and that Resident #3 should be getting what was ordered. No further information and/or documentation was presented prior to the exit conference on 09/11/19 at 12:15 PM, to evidence that the facility staff followed the physician's order for Resident #3's water flush.	F 693		

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F 693	Continued From page 9 This is a complaint deficiency.	F 693	**F 842 Residents record - Identifiable Information** It is the practice of the facility to maintain complete and accurate resident records.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842	**I. Corrective Action** Resident #3 physician's notes were obtained via email. One on one education on wound documentation provided to LPN #4, by director of nursing on 9/10/2019. 100% skin audit on current residents completed by licensed nurses on 9/17/19. Pressure ulcer assessment completed by director of nursing 9/20/19. **II. Identification** All residents have the potential to be affected by this practice. The Director of nursing/designee will conduct an audit of all current residents with pressure ulcers to identify resident's documentation is complete and accurate. **III. Systemic Changes** The Director of Nursing/designee will provide education to licensed nurses on documentation, pressure ulcer assessments and obtaining physician's orders.	

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F 842	Continued From page 10 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of 6 residents in the survey sample (Resident #3). Resident #3's wound and skin care assessments and documentation were not complete, accurately documented, readily accessible or systematically	F 842	**IV. Monitoring** The Director of Nursing/ designee will complete audits of all residents with pressure ulcers to ensure assessments, treatments and documentation are present and correct weekly for 4 weeks and monthly for 2 months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **Date of Compliance** **10/25/19**	

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F 842	Continued From page 11	F 842		

organized.

Findings include:

Resident #3 was originally admitted to the facility on 08/05/10. The most current readmission was on 07/22/19. Diagnoses for Resident #3 included, but were not limited to: anoxic brain injury/damage resulting in a persistent vegetative state, gastrostomy (peg) tube, aphasia, anemia, high blood pressure, history of seizure disorder, DM (diabetes mellitus-uncomplicated), tracheostomy with continuous oxygen use, and intermittent asthma.

The most current full MDS (minimum data set), an annual assessment dated 08/06/19 documented the resident as being in a persistent vegetative state. The resident was also assessed as not having any pressure related skin areas on this MDS, but was assessed for MADS (moisture associated skin damage).

During the entrance conference on 09/09/19 at approximately 1:20 PM with the administrator, a list of residents currently in the facility with any type/stage of pressure ulcer (facility acquired or present upon admission) was requested. The list of resident's with pressure ulcers documented 8 current residents, including Resident #3. Resident #3 was listed as having a stage III pressure area to the sacrum.

During the review of Resident #3's clinical record from 09/09/19 through 09/11/19, no pressure ulcer documentation was found in either the paper clinical record or the electronic clinical record. No skin or pressure ulcer assessments were found to evidence the stage III pressure

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 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED 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 842	Continued From page 12 ulcer was present upon admission. No information information could be located in the resident's electronic clinical record or in the resident's paper chart to evidence that any type of skin assessments or pressure ulcer assessments were being completed. There was no documentation all that gave an accurate and full description of the resident's sacral area, no actual measurements of the open area, no description of the depth of the open area, no description of surrounding skin, color, odor, drainage, no documentation of all treatments attempted, when treatments were started and/or stopped and no documentation of there resident's response to the treatment. On 09/10/19 at 1:45 PM, the administrator and DON (director of nursing) were made aware of concerns regarding Resident #3 developing a stage III pressure ulcer and that there were no assessments documenting the resident's skin and pressure area. The administrator stated that the resident was admitted with the stage III pressure wound to the sacrum when the resident was readmitted to the facility on 7/20/19. The administrator and DON were asked to present any additional information regarding Resident #3. On 09/10/19 at 5:30 PM the administrator, DON and nurse manager (LPN #1) were made again made aware of the above concerns regarding Resident #3 developing a stage III pressure ulcer. No additional information or documentation had been presented on Resident #3's pressure ulcer, as requested at 1:45 PM. The administrator then stated that the wound nurse (LPN #4) had a notebook with	F 842		

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 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED 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 842	Continued From page 13	F 842		

documentation, that included PUSH tools regarding Resident #3's pressure ulcer and again stated that it was present upon admission. The administrator stated that the the wound team does weekly rounds with the physician and it is all documented. The administrator was asked why this was not part of Resident #3's clinical record and not readily accessible, and the administrator stated that the facility had not normally been putting that information in the resident's chart.

The administrator, DON and nurse manager were then asked to present any and all information and documentation regarding Resident #3's stage III pressure ulcer. The administrator stated that they would have all of the information first thing in the morning. The nurse manager also stated that the staff would also present bath sheets (also not part of the resident's clinical record) which were also used for skin documentation.

On 09/11/19 at 8:00 AM, Resident #3's bath records (skin worksheets) were presented from 07/25/19 through 09/09/19. LPN #1 stated that the skin worksheets were completed by CNAs (certified nursing assistants), not nurses. The skin worksheets had sections to include the name of the resident, the date, the room number, and a picture of a body (front and back), which the CNA would document any abnormal areas of the resident's skin on the body. Resident #3's skin worksheets were reviewed and revealed various documentation that included "treatment in progress" with a circle around the sacral area, to a circle around the sacral area that documented "abnormal". Some of the sheets documented, "wound" at the sacral area and some of the bath sheets documented "rash" around the sacral area. Some of the sheets had no documentation

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 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED 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 842	Continued From page 14	F 842		

at all on the back side of the body and one sheet documented that the resident's skin was normal, no areas listed at all. This documentation was not consistent and did not provide any type of assessment information. LPN #1 stated that the CNAs chart in the the electronic computer and also document the skin worksheets. LPN #1 was made aware that the skin worksheets were not accurate. LPN #1 stated that it isn't an assessment, just a tool to help identify skin concerns. LPN #1 did not have any explanation for the above discrepancies and inconsistencies in the skin sheets.

At 9:20 AM on 09/11/19, the administrator and wound care nurse (LPN #4) presented seven wound documents from MD (medical doctor) #2. The administrator and the wound nurse were asked where these documents came from and asked if they were part of or in the "wound" notebook or in resident's chart. The wound nurse stated that the records are emailed to her each week. The wound nurse explained that when the wound team does wound rounds MD #2 will then email his documents to the her and then she in turn will put them into the "wound" notebook, not the resident's chart.

The administrator and wound nurse were asked why the MD did not put his information on the chart while he was at the facility or put the information in the resident's chart the following week. The wound care nurse stated that MD #2 just emails them to her. The wound nurse was asked why these were not in the wound/skin care notebook or in the chart. The administrator then stated that the wound nurse had been on extended leave from the facility from July 15th to September 3rd and during that time her email

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 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED 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 842	Continued From page 15	F 842		

account had been disabled and she wasn't able to get into her email to get the emails from the physician. The wound nurse was then asked who was in charge of wound while she was gone from the facility on expended leave. The administrator stated, "LPN #1." They were then asked if the MD emailed these documents to LPN #1. The administrator stated, "No." The administrator and wound nurse were then asked where the MD documents came from and when they were emailed. The wound nurse stated that they got them the morning of 09/11/19 (during the survey) from the email system from MD #2.

The MD #2 wound documents were dated 7/24, 7/31, 8/7, 8/14, 8/21, and 9/5. These documents were a form with a date at the top. The bottom of each document had a typed entry that documented, "...electronically signed by [Name of MD #2]", but there was not date and/or time stamp to evidence when these documents were completed or when they were electronically signed.

The administrator was asked why someone else on the wound care team was not emailed the information on Resident #3. The wound care nurse stated that, that information comes to her in an email.

The PUSH tool assessment information was reviewed. The dates documented were: 7/20, 7/31, 8/7, 8/14, 8/21, 8/28, and 9/5. All of the PUSH tool documentation was entered and signed off by the wound care nurse (LPN #4) who was on extended leave from 07/15/19 through 09/03/19.

The PUSH tool documentation was signed off by

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 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED 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 842	Continued From page 16 a nurse that was not working or in the facility at the time that the assessments were documented as being completed. There were no wound measurements available in the clinical record or the wound notebook to determine the PUSH tool score, as the MD #2 emails with his assessments were not available until the time of the survey. There were also no measurements or skin assessments available on 07/20/19 to support the PUSH tool documentation for that date. The administrator and DON presented the physician progress notes for Resident #3. One note was dated 09/10/19 and the other the date was illegible. The progress notes were not completely legible. The DON and administrator were asked to read the two progress notes to determine when they were written, and what exactly was documented about Resident #3. Both looked at the progress notes and were unable to read to illegible hand writing. At approximately 11:40 AM, the administrator, DON, LPN #1 and RN #2 were made aware of the above concerns with Resident #3's clinical record and that staff did not document accurate and detailed information in the resident's medical record to reflect the resident's condition and the care and services provided across all disciplines to ensure resident information is available, readily accessible, complete and accurate. No further information and/or documentation was presented prior to the exit conference on 09/11/19 at 12:15 PM, to evidence that Resident #3's clinical records were complete and/or accurate regarding care and services for the care of a stage III pressure ulcer.	F 842		

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 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED 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 880 F 880 SS=D	Continued From page 17 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880 F 880	**F880 Infection prevention & control** It is the practice of the facility to follow infection control protocol. **I. Corrective Action** One on one education on infection control/ incontinent care provided to LPN #4, by director of nursing on 9/10/2019. **II. Identification** All residents who receive incontinent care have the potential to be affected by this practice. The Director of nursing/designee will conduct an audit of all current residents to identify residents require incontinent care to ensure that infection control protocol is followed. **III. Systemic Changes** The Director of Nursing/designee will provide education to licensed nurses and Certified nursing assistants on infection control/incontinent care.	

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 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED ARLINGTON, VA 22204

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F 880	Continued From page 18 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure proper infection control practices during incontinence care for one of 6 residents in the survey sample, Resident #3. Findings include: Resident #3 was originally admitted to the facility	F 880	**IV. Monitoring** The Director of Nursing/ designee will complete audits of residents that require incontinent care to observe that correct procedure is followed 3 times a week for 4 weeks and monthly for 2 months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **Date of Compliance** **10/25/19**	

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 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED 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 880	Continued From page 19	F 880		

on 08/05/10, with the most current readmission was on 07/22/19. Diagnoses for Resident #3 included, but were not limited to: anoxic brain injury/damage resulting in a persistent vegetative state, gastrostomy (peg) tube, aphasia, anemia, high blood pressure, tracheostomy with continuous oxygen use, and intermittent asthma.

The most current full MDS (minimum data set) assessment dated 08/06/19 documented the resident as being in a persistent vegetative state. The resident was totally dependent upon staff for all ADL's (activities of daily living). The resident was assessed being incontinent of both bowel and bladder at all times.

On 09/10/19 at 9:40 AM during a wound care observation, Resident #3 had an incontinent episode of both stool and urine. LPN (Licensed Practical Nurse) #2 was on the left side of the bed, holding the resident (who was rolled on her left side) as LPN #4 removed the resident's brief; the resident had a medium, soft stool bowel movement. LPN #4 had performed hand hygiene and applied gloves prior to removing the resident's brief. LPN #4 wiped and cleaned the stool from Resident #3 by taking the incontinence brief under the resident and folding it over the stool and then moved the incontinence brief out of the way and discarded it into the trash can. LPN #4 then took several clean wipes and wiped the resident's rectal area, several times before discarding the soiled wipes into the trash. Resident #3 then voided. LPN #2 pushed a dry disposable absorbable pad under Resident #3 to absorb the urine. LPN #4 washed her hands and donned new gloves and then took one clean cloth and began wiping the resident's rectal area toward the vaginal area (from back to front), then

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 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED ARLINGTON, VA 22204

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F 880	Continued From page 20	F 880		

folded over the wipe and again wiped from back to front. LPN #4 took two more clean wipes (separate) and wiped the resident in the same manner. LPN #4 took a final clean wipe and wiped the resident's right and left groin area several times and then applied Nystatin powder. LPN #4 did not clean the resident's vaginal area and did not allow the peri area to dry or manually pat dry with a towel prior to applying the powder to the resident's groin and vaginal area.

At 2:20 PM, LPN #1 (nurse manager) stated, "I think I know what policy you are going to ask for." LPN #1 was asked, what policy would that be? LPN #1 stated, "A policy on incontinence care." LPN #1 stated that LPN #2 and LPN #4 came and informed him that they had cleaned Resident #3 incorrectly. LPN #1 then presented the policy on incontinence care.

The policy titled, "Incontinence Care" documented, "...disposable pre-moistened perineal wipes...under pad...cleansing agent, perineal wash...spray...no-rinse...cleanser...disposable brief or pad...assemble equipment...if feces present, remove with toilet paper or disposable wipe by wiping from front to perineum toward rectum. Use...new disposable wipe for each stroke, turn patient side to side to cleanse entire affected area...Gently separate labia and ware area using downward stokes from pubic area to rectal area, cleanse skinfolds...use...new disposable wipe with each downward stroke...pat dry with towel..."

On 09/10/19 at 5:30 PM, the administrator, DON and LPN #1 were made aware of the above concerns regarding Resident #3 in a meeting with

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 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED 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 880	Continued From page 21 the survey team. The administrator stated, "They know better than that." No further information and/or documentation was presented prior to the exit conference on 09/11/19 at 12:15 PM. This is a complaint deficiency.	F 880		