

COMMONWEALTH of VIRGINIA

M. Norman Oliver, MD, MA State Health Commissioner Department of Health
Office of Licensure and Certification

TYY 7-1-1 OR 1-800-528-1120 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1485 Fax (804) 527-4502

March 29, 2019

Mr. Javier Cavero, Administrator Manorcare Health Services-Arlington 550 South Carlin Springs Road Arlington, VA 22204-1022

RE:

Manorcare Health Services-Arlington

Provider Number 495102

Dear Mr. Cavero:

Based on deficiencies cited during the survey ending February 7, 2019, your facility was found not to be in compliance with Federal participation requirements for the long term care Medicare and/or Medicaid programs. On March 26 - 27, 2019, surveyors from the Virginia Department of Health's Office of Licensure and Certification conducted an unannounced revisit to verify that your facility had achieved and maintained compliance for deficiencies cited during the previous survey.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

D=RECTOR (604) 367-2102 ACOTE CARE. (854) 367-2104 GQ#*4 (804) 367-217%



CONG YEARS CAME (BOA) MITCHON Mr. Javier Cavero, Administrator March 29, 2019 Page 2

The survey findings are reflected on the enclosed Statement of Isolated Deficiencies ("A" Form) and/or the Statement of Deficiencies and Plan of Correction (CMS-2567) and/or the Post-Certification Revisit Report (CMS-2567). All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. accordance with §483.10(g) of the Federal requirements, the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

We had presumed, based on your allegation of compliance, that your facility was in substantial compliance. The March 27, 2019 revisit established the facility continues noncompliance with program requirements, including an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of D), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Nicole Keeney, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

2. Address how the facility will identify other residents having the potential to be affected by the

same deficient practice:

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

4. Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained; and

5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through may be Resolution Process. which Dispute Officer's Informal http://www.vdh.state.va.us/QLC/longtermcare/ To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, Mr. Javier Cavero, Administrator March 29, 2019 Page 3

9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings. An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

In regards to previously listed potential remedies, by copy of this letter we are notifying the Centers for Medicare and Medicald Services (CMS) Regional Office and the State Medicaid Agency (DMAS) that this revisit found your facility was not in in substantial compliance with the participation requirements.

Recommended Remedies

The results of the February 7, 2019 survey were forwarded to you under the February 19, 2019 initial letter. At that time, we indicated several remedies could be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (Virginia Department of Medical Assistance Services) if compliance was not achieved. We are, by copy of this letter, notifying the CMS Regional Office and Virginia DMAS that the facility had not achieved compliance with program requirements at the time of the March 27, 2019 revisit. Those agencies will notify you about any remedy they intend to impose.

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The LTC Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at:

"http://www.vdh.virginia.gov/content/uploads/sites/96/2019/02/LTC-facility-survey-response-form.pdf"
We will appreciate your participation.

If you have any questions concerning the content of this letter, please contact me at 804/367-2100.

Sincerely,

Nicole Keeney, LTC Supervisor

· Nucle Keenery

Division of Long Term Care Services

Enclosures

CC:

Roxanne Rocco, Centers For Medicare & Medicaid Services Joani Latimer, State Ombudsman (Sent Electronically) Bertha Ventura, Dmas (Sent Electronically)

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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 most proviously cliend, are identified within this report. The census in this 161 certified bed facility was 128 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents # 101 through 116). (F 584) SS=D An unannounced Medicare/Medicaid revisit to the standard survey conducted 2/5/19 through 2/7/19, was conducted on 3/25/19 through 2/7/19. No complaints were investigated. Corrections are requirements. Uncorrected deficiencies are surfaced and state regulations, the facility has 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 584) SS=D As 3.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable, and homelike environment, allowing the resident to use his or riter personal belongings to the extent possible. (i) This includes ensuring that the resident controlled and homelike environment, allowing the resident controlled and homelike environment, including but not limited to receiving treatment and support for daily living safely. It is the practice of the facility to provide a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely. It is the practice of the facility to provide a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION
An unannounced Medicare/Medicaid revisit to the standard survey conducted 2/5/19 through 2/7/19, was conducted on 3/26/19 through 2/7/19, was conducted on 3/26/19 through 3/27/19. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. Uncorrected deficiencies, as well as a deficiency not previously cited, are identified within this report. The census in this 161 certified bed facility was 129 at the time of the survey. The survey sample consisted of 16 current Resident reviews (F. 584) Safe/Clean/Comfortable/Homelike Environment. The resident has a right to a safe, clean, comfortable and fromelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the teacility maximizes resident independence and does not pose a safety risk. (ii) The facility shall expecise reasonable care for the protection of the resident's property from loss. AMORATORNY DIRECTORS ON PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE TILE (F 500) and do not constitute an agreement with the alleged deficiencies 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 584) Safe/Clean/Comfortable/Homelike Environment It is the practice of the facility to provide a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely	{E 000}	Initial Comments	1	(E 000)			f
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	LABORATOR	V DIRECTOR'S DR PROV	DER/SUPPLIER REPRESENTATIVE'S SIG	INATURE		4/	OKE) 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. It deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: VA0155

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		& MEDICAID SERVICES			·	OMB NO.	0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION		E SURVEY PLETED
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	Continued From pa or theft. §483.10(i)(2) Hous services necessary and comfortable in §483.10(i)(3) Clear in good condition; §483.10(i)(4) Priva resident room, as §483.10(i)(5) Adec levels in all areas; §483.10(i)(6) Com- levels. Facilities in	ekeeping and maintenance to maintain a sanitary, orderly,	(F 56	14)	I Corrective A The chair rail behind the room 231B was fixed. The footboard of the best 321B was fixed. The bed controller in recreplaced. II Identificat	e wall in ed in room	n.
	§483.10(i)(7) For the sound levels. This REQUIREMED by: Based on observe staff interview, the clean homelike ensurvey sample. In located on the wall and had sharp judge footboard on the bed remote had further findings inclusion.	• •			All resident rooms have to be affected by this Entire audit of patient conducted to identify a concerns. III Systemic Ch The Administrator /de develop a plan to systemic correct all areas identicomplete audit of faci	oractice. rooms wa naintenar anges signee wi ematically fied from	is ice
	the bed was obse	rved cracked and having sharp				- / / / / / / / / / / / / / / / / / / /	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XX) MULTIS A. BUILDING	PLE CONSTRUCTION	OCS) DATE SURVEY COMPLETED R-C
	·	495102	B. WING		03/28/2019
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(F 584)	was not completely and the bed remote resident who reside chair rail had been transferred to the ro. The resident stated remote and held up which showed fraye of the cord which with the resident stated footboard on her be to the bed frame. To observed attached screws into the bed commend on 03/26/19 at 2:00 assistant (CNA #2) for the resident in 2 room and interview. The CNA stated he order needs and stentered in the elect maintenance depair on 03/26/19 at 2:10 maintenance depair rail during his Saturday, 03/23/19 of the issues with the remote. OS #2 stated the work order requirements at not received at the work order requirements.	es, the footboard on the bed screwed to the bed frame, had frayed wires. The id in 231-B bed stated the in disrepair since she corn a couple of weeks ago, she needed another bed the one attached to her bed, ad wires coming from the top as attached to the remote, that last night she noticed the id was loose and not attached he footboard on the bed was with enty two of the four frame. D.p.m., the certified nursing who routinely provides care 31-B was accompanied to the ed regarding the above items, was not aware of the work ated all work orders were ronic system for the tment to review and complete. D.p.m., the interim or (OS #2) was interviewed orders for the above items in mpanied by the OS #2 to the interior on inspections on. He stated he was not aware he footboard and the bed ted typically nursing entered lests in the electronic system is department; however, he by orders for these items. He	{F 584	The Administrator/design educate all staff to on confroom rounds to identify a needing repair along with reporting system for main complete necessary repair. The Administrator/design complete random environ audits weekly for 4 week randomly thereafter for 2. Data collected will be for Quality Assurance and P. Improvement Committee and action, as appropriat Quality Assurance and F. Improvement Committee determine the need for fand/or action plans.	reas the tenance to rs. nee will mental s and months. rwarded to reformance e for review e. The reformance e will muther audits
<u>.</u>		of work order requests for the as contracting with other			

DEPART	MENT OF HEALT	HAND HUMAN SERVICES		Y	FORM.APPROVED 0 <u>MB NO. 0938-0391</u>
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(F 584) (F 656) SS=D	These findings we administrator, dire director of nursing meeting on 03/26/Develop/Implement CFR(s): 483.21(b) \$483.21(b) Comp §483.21(b) Comp §483.21(b) (1) The implement a compare plan for each resident rights set §483.10(c)(3), that objectives and timmedical, nursing, needs that are ideasessment. The describe the follow (i) The services the or maintain the rephysical, mental, required under §483.24, §4 provided due to the under §483.24, §4 provided due to the treatment under §483.10, in treatment u	and vendors to get the work as soon as possible. The reviewed with the cotor of nursing, assistant and corporate staff during a 19 at 4:00 p.m. The Comprehensive Care Plan (1) The comprehensive care plan at 3483:10(c)(2) and the comprehensive care plan must be comprehensive care plan must wing the comprehensive care plan must will be	{F 584}	F656 Developme Comprehensive Car It is the practice of the fadevelop a comprehensive centered care plan for ear of the facility and the facility will conduct all current residents to it residents who have a Formula in the facility will conduct all current residents to it residents who have a Formula in the facility will conduct all current residents to it residents who have a Formula in the facility will conduct all current residents to it residents who have a Formula in the facility will conduct all current residents to it residents who have a Formula in the facility will conduct all current residents and the facility will conduct all current residents and the facility will conduct all current residents who have a Formula in the facility will conduct all current residents and the facility will conduct all current residents.	cility to e person ch resident. tion care plan to catheter. catheters affected. t an audit of dentify bley to ensure
	recommendations findings of the PA rationale in the re	s. If a facility disagrees with the SARR, it must indicate its sident's medical record. with the resident and the		that they have appropris	ate care plans

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				C		. 0938-0391
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{F 656}	desired outcomes. (B) The resident's inture discharge. F whether the resident community was as local contact agent entities, for this put (C) Discharge plan plan, as appropriat requirements set to section. This REQUIREME by: Dased on staff interecord review, the care plan for the ur of 16 residents, Referrings were: Resident #116 was facility on 02/07/20 readmitted on 03/0 included but were chronic kidney dishypertension, diab	poals for admission and preference and potential for acilities must document of the sessed and any referrals to ples and/or other appropriate pose. In the comprehensive care e, in accordance with the orth in paragraph (c) of this or the pose of a Foley catheter for one	{F 6	56)		The Director of Nursing/will provide education to nurses on development of Monitoring The Director of Nursing/will randomly audit resid Foleys weekly for 4 week monthly for 2 months. Data collected will be for Quality Assurance and Polymprovement Committee and action, as appropriate Quality Assurance and Polymprovement Committee and action, as appropriate Quality Assurance and Polymprovement Committee and action, as appropriate Quality Assurance and Polymprovement Committee and Comm	designed licensed care plants with the care plants	d lans.
	with an ARD (asses 01/22/2019, asses impaired with a co	ge MDS (minimum data set) assment reference date) of sed Resident #116 as severely gnitive summary score of "06".				determine the need for fu and/or action plans.	rther a	adīts
	during initial tour of was heard yelling Resident #116 sta	approximately 08:05 a.m., if the facility, Resident #116 out, "Come here, come here." ted, "Help methere is			ļ ,	Date of Compli- 4/16/19	ince	
	something in my p	enisit hurts." LPN (licensed			<u> </u>	(24) (24) (24) (24) (25) (25) (25) (25) (25) (25) (25) (25	- A. A.	

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		AND HUMAN SERVICES & MEDICAID SERVICES			·		APPROVED 0. 0938-0391
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{F 656}	practical nurse) #1 was asked to come repeated to LPN #1 pulled the covers b stated, "He has a F observed exiting th The clinical record 10:00 a.m. There (Physician order sh were there any ent catheter. At approximately 2 (registered nurse) should be on Resid stated, "Yes." She	was at the nurses station and to the room. Resident #116 my penis hurts. LPN #1 ack on Resident #116 and oley." The Foley catheter was e side of Resident #116's brief. was reviewed at approximately were no orders on the POS neet) for the Foley catheter, nor ries on the care plan for the #10 p.m., the unit manager, RN #1 was asked if the catheter lient #116's care plan. She was informed that no seen observed on the care		56}			
{F 657} SS=D	at approximately 3 was discussed with the administrator, the ADON (assistanurse consultant. No further informate exit conference on Care Plan Timing & CFR(s): 483.21(b) §483.21(b) Compr. §483.21(b) (2) A co.	and Revision	{F 6	57}			
	the comprehensive	n 7 days after completion of assessment. interdisciplinary team, that					

FORM APPROVED

DEPART	MENT OF HEALTH	AND HUMAN SERVICES 8 MEDICAID SERVICES		·	OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495102	B. WING_		R-C 03/28/2019
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	ARE HEALTH SERV	ICES-ARLINGTON		550 SOUTH CARLIN SPRINGS ROAD ARLINGTON, VA 22204	
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(F 657)	Continued From pi	age 6	(F 65	- F	_
	includes but is not			F657 Care Plan Ti	ming and
	(A) The attending	physiolan.		Revision	
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	(C) A nurse aide w	ith responsibility for the	ļ	It is the practice of the f	· .
,	resident.		-	review and revise the co	mprenensive
	(D) A member of f	ood and nutrition services staff.]	care plan.	
	(E) to me extent p	racticable, the participation of ne resident's representative(s).	1		
	An explanation mu	ist be included in a resident's			
	medical record if t	he participation of the resident		т	
	and their resident	representative is determined		Corrective Ac	tion
	resident's care pla	the development of the		Corrective Ac	HUIL
	(F) Other appropri	ate staff or professionals in			
	disciplines as dete	rmined by the resident's needs		Resident #113 care plan	· was
	or as requested by	y the resident.		reviewed and revised to	
[(iii)Reviewed and	revised by the interdisciplinary seesment, including both the		sleeves	
ļ	comprehensive at	nd quarterly review		Sied ves	!
ļ	assessments.				
ļ	This REQUIREME	ENT is not met as evidenced		II	
j	Dy: Resert on cheery	ation, staff interview, and clinica	از	Identification	on e
	record review, the	facility staff failed to review and	11		
	revise the compre	hensive care plan for one of 16		All residents with Geri-	sleeves have
	residents, Reside	nt #113.		the potential to be affect	ted by this
1	Regident #113's c	are plan was not revised to		practice.	
	reflect Geri sleeve	es to be placed on the resident.			
		A		The Director of nursing	
	The Findings Inch	nge:		will conduct an audit of	
	Resident #113 wa	s admitted to the facility on		residents to identify resi	
1	02/23/17. The m	ost current MDS (minimum data		have Geri-sleeves to ens	
	set) was an annu	ai assessment with an		have appropriate care pl	ans and the
1	assessment refer	ence date (ARD) of 3/4/19. ed: diabetes, and left arm		Kardex is reflective.	
	paralysis. Reside	nt #113 was assessed with a			

TATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	A BUILDING	E GOINSTRUCTION	COM R-	C C
		495102	B. WING		1 '	8/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV			TREET ADDRESS, CITY, STATE, ZIP CODE 50 SOUTH CARLIN SPRINGS ROAD ARLINGTON, VA 22204		
(X4) ID RREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) CROSS REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XIS) COMPLE DAT
{F 657}	Cognitive score of 1 On 3/26/19 the clin Resident #113's cu documented a phy 10/29/18 that read every day [give pat	5, indicating cognitively infact. ical record was reviewed. rrent physician's order set sician order initiated on "Geri Sleeve to both arms ient 2 pairs for alternative	{F 657}	TII Systemic Cha The Director of Nursing will provide education t nurses on revision of ca reflect person centered of	/designee o licensed re plans to	
	administration reco	hygiene) in the morning for skin integrity." Review of Resident #113's treatment administration record (TAR) indicated that the Geri sleeves were to be placed on Resident #113 at 6:00 AM daily. Resident #113's care plan and Kardex were reviewed and did not indicate Geri sleeves as an intervention for skin integrity or any other part of the comprehensive care plan.		IV Monitorin	B	i i
	reviewed and did n intervention for skil the comprehensive On 03/26/19 at 11:			The Director of Nursing will complete random a residents with Geri-slee for 4 weeks and monthly months.	udits of ves weekl	
	the comprehensive care plan. On 03/26/19 at 11:30 AM, Resident #113 was observed in her room sitting in a wheel chair. Resident #113 was not wearing Geri sleeves and when asked, Resident #113 verbalized that they were washed the other day and had not been pur back on. Resident #113 was asked if there was another pair that the staff could put on while the other pair of Geri sleeves were in the laundry. Resident #113 verbalized that she was only aware of the one pair.		Data collected will be for Quality Assurance and Improvement Committee and action, as appropriate Quality Assurance and Improvement Committee determine the need for the control of the co	Performante for revie te. The Performante will	ew	
	observed, this time was asked if staff I Resident #113 ver placed the Gen sle On 3/26/19 at 2:25 assistant (CNA #1	PM, Resident #113 was again alaying in bed. Resident #113 had placed the Geri sleeve on balized that the staff had not seves on all day. PM, the certified nursing assigned to Resident #113 becoming the Geri sleeves.		and/or action plans. V Date of Compl 4/16/19		

		AND HUMAN SERVICES				1 APPHOVED 1. 0938-0391
STATEMENT		(A) PROVIDENCIUM NUMBER:		F CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495102	B. WING		1	R-C <u>/28/2</u> 019
	ROVIDER OR SUPPLIER	ICES-ARLINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH CARLIN SPRINGS ROAD ARLINGTON, VA 22204		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE.
	Resident #113 nee asked how do CNA care for a Resident nurses give the CN is supposed to have On 3/26/19 at 2:30 who was assigned interviewed. RN #2 physician orders arwasn't aware of the has night shift sign out and therefore s prompted to make intact. RN #2 was not part of the care she did not know. On 3/26/19 at 4:00 presented to the act (DON) and regional director of operation understood the concorrected. No other evidence conference on 3/27 Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of Quality of care is a applies to all treatment of the care is a applied to the care is a a a a a a a a a a a a a a a a a a	that she was not aware that ded Geri sleeves. When as get information regarding that the IAs a report on what a resident in place. PM, registered nurse (RN) #2 to Resident #113 was reviewed Resident #113's and TAR and verbalized that she corder because the TAR onlying off that the task is carried the (RN #2) would not be sure the Geri sleeves were asked why are the geri sleeve plan. RN #2 verbalized that PM, the above finding was diministrator, director of nursing all vice president. The regional ons verbalized that he meern and it would be was presented prior to exit 7/19.	{F 684			
	assessment of a n	esident, the facility must ensure live treatment and care in				

accordance with professional standards of

DEPART	MENT OF HEALTI	HAND HUMAN SERVICES			C		0938-0391
		E & MEDICAID SERVICES	DYM MUD	TIO G	TONISTER INTRIN	(X3) DATE	
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	V Brito	•			i
		495102	8. WING			R 03/2	C 28/2019
NAME OF F	ROVIDER OR SUPPLIEF	1			EET ADDRESS, CITY, STATE, ZIP CODE	•	
MANORO	ARE HEALTH SER	VICES-ARLINGTON	-		SOUTH CARLIN SPRINGS ROAD LINGTON, VA 22204		
(X4) ID PREFIX TAG	JEANN DEEMIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE 1	(X5) COMPLETION DATE
{F 684}	practice, the component plan, and the This REQUIREMI by: Based on observe record review, the physician's orders integrity for one of Resident #113 did Geri sleeves (arm The Findings Incl. Resident #113 we 02/23/17. The mases sament refer Diagnoses included paralysis. Resident #113's documented a phin/29/18 that real every day (give physician) in the miner Review of Resident #113's documented a phin/29/18 that real every day (give physician) in the miner refer on 03/26/19 at 1 observed in her resident #113's we have the component for the served in her resident #113's we residen	prehensive person-centered residents' choices. ENT is not met as evidenced ation, staff interview, and clinical facility staff failed to follow for treatment and care of skin faile to follow for treatment and care of skin faile to follow for treatment and care of skin faile to follow for treatment and care of skin faile to follow for treatment and care of skin faile to the facility on ordered protectors) on. I not have physician ordered protectors on. I not have physician ordered protectors on. I not have physician ordered protectors on. I as admitted to the facility on ost current MDS (minimum data al assessment with an ence date (ARD) of 3/4/19. I at #113 was assessed with a fail fail fail fail fail fail fail fa		84)	I Corrective Actio A physician order was obtathe Geri-sleeves for Reside II Identification All residents who receive porders for Geri sleeves hav potential to be affected by practice. The facility will conduct an identify residents who have sleeves to ensure that phys orders are followed and pecentered care is reflected.	n ined for ant #113. ohysician e the this a audit to e Geri- ician	1 :
	when asked, Res	sident #113 verbalized that they				_	

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			<u></u>		0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDENSUPFLIENULIA IDENTIFICATION NUMBER:	(AZ) MUC		MSTRUSTISK	1	PLETED
		495102	B. WING		,	93/2	28/2019
	ROVIDER OR SUPPLIER ARE HEALTH SERV			550	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH CARLIN SPRINGS ROAD INGTON, VA 22204		
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROP DEPICIENCY)	D BE	(XS) COMPLETION DATE
(F 684)	another pair that the other pair of Geri's Resident #113 veril aware of the one pair that the aware of the one pair that the construction of the one pair that the construction of the construction of the care for a Resident #113 ness asked how do CN/care for a Resident #113 ness give the CN as supposed to have the construction orders a wasn't aware of the construction of the care for a Resident #113 ness give the CN as supposed to have the construction orders a wasn't aware of the construction of the care for a Resident #113 ness give the CN as supposed to have the construction orders a wasn't aware of the construction orders a wasn't aware of the construction of the care for a Resident #12 wasn't aware of the construction of the care for a Resident #12 wasn't aware of the CN wasn't awa	#113 was asked if there was a staff could put on while the leeves were in the laundry. Dalized that she was only air. PM, Resident #113 was again a laying in bed. Resident #113 had placed the Geri sleeve on belized that the staff had not neves on all day. PM, the certified nursing assigned to Resident #113 becoming the Geri sleeves. I that she was not aware that needed Geri sleeves. When as get information regarding at, CNA #1 verbalized that the NAs a report on what a resident		84}	The Director of Nursing/will provide education to nurses on performing 24 check to identify physicism. IV Monitoring The Director of Nursing will randomly audit resideri-sleeves weekly for monthly for 2 months. Data collected will be for Quality Assurance and Improvement Committee and action, as appropriate Quality Assurance and Improvement Committee and action, as appropriate Quality Assurance and Improvement Committee and action plans. V Date of Company 4/16/19	designe licensed hour che an order / designe dents wi 4 weeks orwarded Performate for rev ate. The Perform te will further a	ee th s and d to ance view ance

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DEPART	MENT OF HEALTH	I AND HUMAN SERVICES		·	OMB NO. 0938-0	
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIENCUA IDENTIFICATION NUMBER:	A BUILDING	z powie naby TISM	R-C O3/28/2018 TY, STATE, ZIP CODE N SPRINGS ROAD 22204 ERS PLAN OF CORRECTION RECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY) Bowel/Bladder Incontinence, Catheter, UTI I Corrective Action der was obtained for resident for a Foley catheter and his of care was revised to reflect in centered care. ent #116 catheter was anchored ently per manufacturer's immendation. II Identification	
		495102	B. WING		03/28/2019	١.,
NAME OF F	ROVIDER OR SUPPLIER			THEET ADDRESS, CITY, STATE, ZIP CODE 150 SOUTH CARLIN SPRINGS ROAD		
MANORO	ARE HEALTH SERV			TRLINGTON, VA 22204	PARA INC.	
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR	JLD BE COMPLET	rion
(F 684) F 690 SS=D	conference on 3/2 Bowel/Bladder Inc	was presented prior to exit 7/19. ontinence, Catheter, UTI	(F 684) F 690	Catheter, U		!
	resident who is co admission receive maintain continen	facility must ensure that ntinent of bladder and bowel on a services and assistance to be unless his or her clinical comes such that continence is		An order was obtained #116 for a Foley cathet plan of care was revise	for resident er and his	
	incontinence, bas- comprehensive as ensure that- (i) A resident who indwelling cathete resident's clinical catheterization was (ii) A resident who indwelling cathete is assessed for re as possible unles demonstrates tha and (iii) A resident who receives appropri prevent urinary to continence to the \$483.25(e)(3) For incontinence, bas comprehensive a ensure that a res receives appropri	enters the facility with an or or subsequently receives one moval of the catheter as soon is the resident's clinical condition t catheterization is necessary; o is incontinent of bladder ate treatment and services to act infections and to restore		Resident #116 catheter correctly per manufact recommendation.	ion ey catheters e affected by ng/ designee of all current esidents who o ensure that eing followed, s reflective in	

DEPART	MENT OF HEALT	H AND HUMAN SERVICES		·	FORM APPROVED OMB NO: 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XI) PROVIDENSUPPLIENCIA IDENTIFICATION NUMBER: 495102		(X2) MULTIPLE CON A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED FI-C 03/28/2019		
	PROVIDER OR SUPPLIE CARE HEALTH SEF	and the control of the second of the control of the	550 SO	ADDRESS, CITY, STATE, ZIP CODE UTH CARLIN SPRINGS ROAD GTON, VA 22204	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TTATEMENT OF DEFICIENCIES ICY MUST BE PAECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 690	possible. This REQUIREN by: Based on obser interview and clir staff failed to pro	IENT is not met as evidenced vation, staff interview, resident nical record review, the facility yide care and services related to	F 690	procedure is followed for the catheter per manufar guidelines.	
	a Foley catheter #116. Resident #116 dindwelling cathet planned, the cathet when the facility	for one of 16 residents, Resident id not have orders for an er, the catheter was not care heter was not anchored, and staff anchored the catheter it was nufacturer's recommendations.		Systemic Char The Director of Nursing will provide education nurses on following phases well as the manufact for anchoring of Foley	g/ designee to licensed ysician orders ure guidelines
	Resident #116 w facility on 02/07/ readmitted on 03 included but well chronic kidney of hypertension, di- reflux uropathy, A significant cha- with an ARD (as	ras originally admitted to the 2018 and most recently 3/09/2019. His diagnoses is not limited to: dysphagia, lisease, congestive heart failure, abetes mellitus, obstructive and and vescular dementia.		IV Monitoria The Director of Nursin will randomly audit res Foley catheters weekly and monthly for 2 mon	g/ designee sidents with for 4 weeks
	impaired with a On 03/26/2019 during initial tou was heard yellin Resident #116 s something in m practical nurse) was asked to co	essed Resident #116 as severely cognitive summary score of "06". at approximately 08:05 a.m., of the facility, Resident #116 ig out, "Come here, come here." tated, "Help methere is y penisit hurts," LPN (licensed #1 was at the nurses station and ome to the room. Resident #116 and the back on Resident #116 and		Data collected will be a Quality Assurance and Improvement Committe and action, as appropri Quality Assurance and Improvement Committed determine the need for and/or action plans.	Performance tee for review ate. The Performance tee will

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		. 0	MB NO. 0938-0391
		& MEDICAID SERVICES	OM MARKET	E CONOTINUOTION	(X3) DATE SURVEY COMPLETED
STATEMENT OF DEFICIENCIES TAN) PHOVIDER SOCIAL IDENTIFICATION NUMBER:		A. BUILDING	•	R-C	
			•		
495102			B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	03/28/2019
NAME OF F	ROVIDER OR SUPPLIER	백, 원인 시민 등		50 SOUTH CARLIN SPRINGS ROAD	
MANORO	ARE HEALTH SERV	ICES-ARLINGTON		ARLINGTON, VA 22204	
(X4) ID PREFIX TAG			PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION I
F 690	Continued From page 13 stated, "He has a Foley." The Foley catheter was observed exiting the side of Resident #116's brief.		F 690	\mathbf{v}	
	LPN #1 was asker She stated, "Yes", exiting the brief. S back. There was Besident #116's le	d if the catheter was anchored. and pointed to the tubing the undid the brief and pulled it no anchor observed on the stated, "His penis is notifiered Resident #116 pain		Date of Compliance 4/16/19	
	medication. The clinical record 10:00 a.m. There (Physician order s	I was reviewed at approximately were no orders on the POS heet) for the Foley catheter, nor tries on the care plan for the	1		
	observed sitting a asked if his cathe morning. She did up from the nurse supply cart on the and started towar was asked if she She stated, "Yes, (registered nurse station. Should be anchor to Resident #116 room with a hove into his bed. The	2:05 p.m. Resident #116 was this bedside. LPN #1 was ter had been anchored that not answer the question, but got is station and walked to a unit. She obtained and item ds Resident #116's room. She had an anchor for the catheter. The unit manager, RN #1 came down the hall to the he was asked if catheters ed. She stated, "Yes," She went iff to get Resident #116 back unit manager and this surveyor.			
	catheter required "Yes." She was a on the care plan- informed that no observed on the	unit manager was asked if the physician orders. She stated, isked if the catheter should be She stated, "Yes." She was physician orders had been clinical record, nor had any n observed on the care plan.			

DEPART	MENT OF HEALTH	HAND HUMAN SERVICES	•				APPROVED . 0938-0391	
		(XI) PROVIDED SUPPLIES (CITAL IDENTIFICATION NUMBER:	(XP) MULTIPLE CONSTRUCTION A. BUILDING			CON	(X3) DATE SURVEY	
495102			B. WING				28/2019	
NAME OF P	ROVIDER OR SUPPLIEF	1			REET ADDRESS, CITY, STATE, ZIP CODE D SOUTH CARLIN SPRINGS ROAD		_	
MANORO	ARE HEALTH SERV	VICES-ARLINGTON			RLINGTON, VA 22204		-	
(X4) ID PREFIX TAG	(FACH DEFICIENT	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LID BE	(X5) COMPLETION DATE	
F 690	Summary STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 At approximately 2:15 p.m., Resident #116's was observed fying on his bed. His parts were pulled down. An anchor was observed on the outside of his thigh, the catheter was not attached to the anchor. The unit manager stated to LPN #1, "No, it goes on the inside of his thigh." The unit manager removed the anchor and attempted to place it on the inside of Resident #116's thigh. She stated, "It needs skin prep under it so it will stick." LPN #1 left the room. The unit manager looked around the room and then left stating to LPN #1 who was down the half at a supply cart, "I have one here." Both LPN #1 and the unit manager returned to the room with another anchor. The unit manager placed the anchor on Resident #116's inner thigh. She then secured the catheter by pulling the anchor ties across both the catheter tubing and the port used to inflate the Foley catheter balloon with water. The unit manager was asked if the catheter was suppose to be secured with the anchor ties over both the water port and the foley tubing. She stated, "Yes." A copy of the facility policy regarding catheter care was requested and presented by the DON (director of nursing). Per the facility policy. "CATHETER", Equipment:Securement device or Velcro leg strap device as ordered or clinically indicatedProcedure: Verify physician's ordersecure catheter tubing to patient's leg using a securement device or Velcro leg strap as ordered and clinically indicated-prevents traction on the urethral [sic]." The DON was asked how the catheter tubing should be anchored. She stated, "I haven't			90				
	should be ancho	red. She stated, "I haven't		: =-	- III- VAO155 If contin	uation she	et Page 15 of 1	

		AND HUMAN SERVICES			0		APPROVED 0938-0391	
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PER TRIBLE CONTROL NUMBER:	A BUILDING		ניסודסטחדטאסס	(YA) DATE SURVEY		
		495102	B. WING				03/28/2019	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ARLINGTON				55	REET ADDRESS, CITY, STATE, ZIP CODE O SOUTH CARLIN SPRINGS ROAD RLINGTON, VA. 22204			
(X4) ID PREFIX TAG			ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETION DATE	
F 690	A copy of the manuscripper of the anc. The manufacturer's wrapper included a secure the cathete should only be place port used to inflate. The ADON (assists observed coming of approximately 3:15 had checked the awas shown a diagranchor was. She sport at the 'Y'." During an end of that approximately 3 was discussed with the regional direct the nurse consultation.	e in a long time, I need to ask." Ifacturer's instructions on the hor was requested. Is instructions on the Anchor diagram of the proper way to r. Per the diagram, the anchor ded across the tubing of the the balloon. In director of nursing) was but of Resident #116's room at 5 p.m. She was asked if she nichor. She stated, "Yes." She ram and asked where the stated, "It is across the balloon he day meeting on 03/26/2019 in the DON, the administrator, or of operations, the ADON and ant.		690				