COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

M. Norman Oliver, MD, MA
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

November 15, 2019

Ms. Nichelle Jones Williams, Administrator
Regency Care Of Arlington, Llc
1765 South Hayes Street
Arlington, VA 22202

RE: Regency Care Of Arlington, Llc
Provider Number 495114

Dear Ms. Jones Williams:

An unannounced abbreviated standard (complaint) survey, ending November 13, 2019, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. One (1) complaint was investigated during the survey. One (1) complaint was substantiated, with deficiencies.

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

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, 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. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was 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 the Office's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.virginia.gov/licensure-and-certification/the-division-of-long-term-care/.

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, 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.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).
- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,
- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

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 this letter, please contact me at (804) 367-2100.

Sincerely,

Nicole Keeney

Nicole Keeney, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman (Sent Electronically)
Bertha Ventura, Dmas (Sent Electronically)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495114	A. BUILDING _____ B. WING _____	C 11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF ARLINGTON, LLC	1785 SOUTH HAYES STREET ARLINGTON, VA 22202

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid abbreviated standard survey was conducted on 11/13/19. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.

The census in this 240 certified bed facility was 171 at the time of the survey. The survey sample consisted of one current resident review (Resident #1).

F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2)	F 825	Resident #1 was evaluated for therapy and authorization was obtained with resident starting therapy on 11/4/2019. All residents in the facility that have orders for therapy have the potential to be affected by this citation.	11/23/2019

§483.65 Specialized rehabilitative services.
§483.65(a) Provision of services.
If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-

§483.65(a)(1) Provide the required services; or

§483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nichelle Jones Williams | TITLE: LNHA | (X6) DATE: 11/26/19

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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clinical record review and complaint investigation, the facility staff failed to promptly provide physical and occupational therapy services for the one resident in the survey sample (Resident #1).

The findings include:

Resident #1 was admitted to the facility on 10/23/19 with diagnoses that included end stage renal disease, status post aortic dissection repair, morbid obesity, atherosclerotic heart disease, respiratory failure, depression and obstructive sleep apnea. The minimum data set (MDS) dated 10/29/19 assessed Resident #1 as cognitively intact.

On 11/13/19 at 11:15 a.m., Resident #1 was interviewed about therapy services provided since his admission to the facility. Resident #1 stated he was admitted on 10/23/19 for rehabilitation following surgical repair of an aortic aneurysm. Resident #1 stated occupational therapy (OT) and physical therapy (PT) performed a screening exam on 10/24/19 but he did not actually start therapy until over a week and a half later. Resident #1 stated he talked with the social worker and he was told there was a delay in verification of his payer source. Resident #1 stated the business office manager was on vacation and that may have caused the delayed payment verification. Resident #1 stated he was "private pay" and had already made arrangements and payments to the facility for care. Resident #1 stated he was eager to get started with therapy upon admission so he could get home as soon as possible. Resident #1 stated he was not evaluated for therapy services until 11/2/19 with actual therapy starting on 11/4/19.

Based on record review completed by Dana Chung Director of Rehabilitation Services of residents with orders for therapy needing verification which started on 11-6-2019 there were no other residents affected by this citation.

The facility administrator or designee will educate the Business Office and Rehab Director on the process for obtaining authorization for therapy services upon admission to the facility.

The Administrator or designee will audit private pay residents needing verification before starting therapy weekly for four weeks to

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Resident #1's clinical record documented a physician's order dated 10/23/19 for OT and PT evaluations with treatment as indicated. The admitting physician's history and physical dated 10/25/19 documented the resident's treatment plan included PT and OT to address "deconditioning."

Resident #1's baseline care plan initiated on 10/23/19 listed PT/OT therapy services as an initial goal and documented, "Resident is receiving therapy services...The resident will participate in therapy to achieve their functional goals..." Physical functional goals listed in this care plan included, "Improve functional status...Minimize decline..."

The record documented a rehabilitation admission screening form dated 10/23/19. This form assessed that the resident was a candidate for therapy services and required services for improvement in functional assistance with dressing, toileting, walking, transferring, bed mobility and strength.

Physical therapy and OT did not evaluate Resident #1 until 10 days after his admission, with actual treatment starting twelve days after admission on 11/4/19. A physical therapy evaluation and treatment plan for Resident #1 was documented on 11/2/19. This PT evaluation assessed the resident as requiring minimal assistance for bed mobility, transfers and gait (walking 40 feet with two-wheeled walker). An occupational therapy evaluation and treatment plan for Resident #1 was documented on 11/3/19. This OT evaluation assessed the resident as requiring minimal assistance for bathing, toileting.

ensure verification is obtained in a timely manner and the resident receives therapy services according to physicians' orders.

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dressing and as independent for self-feeding. A physician's order was documented on 11/2/19 for physical therapy five times per week for four weeks; an order dated 11/3/19 required occupational therapy five times per week for four weeks.

Interdisciplinary progress notes in the clinical record made no mention of the delay in Resident #1's occupational and physical therapy services.

On 11/13/19 at 12:15 p.m., the rehab director (other staff #1) was interviewed about Resident #1's delayed therapy services. The rehab director stated Resident #1 was a private pay resident and services were not covered under Medicare. The rehab director stated OT and PT "screened" Resident #1 for needed services on the day of his admission (10/23/19). The rehab director stated this form indicated the resident was a candidate for services and the form was sent to the business office on 10/24/19 for verification of his payment arrangements. The rehab director stated, "Until we get approval, we don't do any billable services.". The rehab director stated she got no response from the business office until 11/1/19. The rehab director stated once the verification form was received, therapy services were started on 11/2/19. The rehab director stated an initial evaluation was performed and then orders were entered for services. The rehab director stated the resident currently participated in OT and PT five times per week based upon the resident's assessment. The rehab director stated she was not aware of any decline in the resident's status due to the delay as the resident was "minimal assist" at the start of therapy. When asked how long it usually took to get verification for payment, the rehab director

The results of the audits will be reviewed during monthly QA committee meeting and random follow-up audits to ensure continued compliance.

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stated, "It varies." The rehab director stated sometimes responses were returned in two days and other times it took a week. The rehab director stated Resident #1's need for therapy and payment verification was brought up in the morning meetings with other staff members but she got no response until 11/1/19.

The rehab director presented a copy of Resident #1's payment verification form. The form documented the request from therapy was made on 10/24/19. The business office manager signed the verification form on 11/1/19.

The business office manager was on vacation at the time of the survey and not available for interview.

On 11/13/19 at 1:05 p.m., the Medicaid specialist (other staff #5) working in the business office was interviewed. The Medicaid specialist stated the business office manager was on vacation when Resident #1's payment form was sent from therapy. The Medicaid specialist stated she had no information regarding the processing of Resident #1's therapy payment form.

On 11/13/19 at 1:15 p.m., the administrator was interviewed about Resident #1's delayed therapy services. The administrator stated the business office manager was on vacation when Resident #1's request form was sent from therapy for verification. The administrator stated the Medicaid specialist working in the office during that time was in training and not aware the form needed to be approved and returned to therapy. The administrator stated the delay was caused because the payer source was not reviewed and the approval form was not promptly sent back to

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therapy. The administrator stated she recognized a failure in initiating therapy services for Resident #1.

On 11/13/19 at 1:20 p.m., the regional director of reimbursement (administration staff #3) was interviewed about the delayed payment approval. The regional director stated she was in the facility when Resident #1 was admitted. The regional director stated there were no issues with Resident #1's payment arrangements. The regional director stated the business office manager was on vacation when the approval form was sent from therapy. The regional director stated the expected response time for therapy payment approval was from 24 to 48 hours.

This finding was reviewed with the administrator and director of nursing on 11/13/19 at 3:30 p.m.

This was a complaint deficiency.

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