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 12/14/2021

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 An unannounced Medicare/Medicaid abbreviated survey was conducted 12/13/2021 through 12/14/2021. Three complaints were investigated during the survey and are as follows: VA00052479 substantiated with related deficiencies; VA00051322 unsubstantiated; and VA00053853 unsubstantiated. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in these 240 certified bed facilities was 127 at the time of the survey. The survey sampleconsisted of 2 current resident reviews and 2 closed record reviews.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 12/25/21

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 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of complaint investigation, the facility failed to develop a care plan for the care and safeguard of dentures for one of 4 residents, Resident #3 The findings include: Resident #3 was admitted to the facility on 5/27/21 with the most recent admission on 8/13/21. Diagnoses for Resident #3 included: Renal failure, stroke, congestive heart failure, and malnutrition. The most current MDS (minimum data set) was a 5 day assessment with an ARD (assessment reference date) of 8/20/21. Resident #3 was assessed with a cognitive score of 11 indicating moderate cognitive impairment.	F 656	F656 Develop/Implement Comprehensive Care Plan 100 % audit will be completed of all residents in the facility. Residents with dentures were identified with the following process put in place • All current residents and newly admitted patients will have an oral assessment completed, the utilization of dentures will be documented on the assessment. Specification for upper and lower or single use of one of the two shall be documented	12/30/21

	• Telephone orders will be written for the safeguarding of the Dentures. • Care plans will be created to document the care of the dentures. • MDS department will review all care plans to ensure 100% compliance with this requirement. In-service initiated for all procedures outlined above by nurse educator and nursing supervisors for nursing staff on 12/15/2021. Audits will be conducted on all admissions weekly for the next 90 days by medical records manager. Findings will be reviewed each month during monthly QAPI meeting. Director of Nursing or designee will review findings with the Administrator for review with the QAPI Committee. Variances discovered in audit will be reviewed by the following members of the QAPI committee: (Medical Director or Designee, Director of Nursing, Dietician, Social Services Director, and Dietary Services Director) Plan of correction will be adjusted as necessary dependent upon success of audits for achieving and maintaining compliance. Date of compliance 12/30/2021	

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F 656	Continued From page 2 Resident #3 was discharged on 8/24/21. On 12/13/21 Resident #3's medical record was reviewed. Documentation in the nursing notes and MDS assessments indicated Resident #3 was discharged to the hospital on 6/10/21 and returned to the facility on 6/22/21. A registered dietitian (RD) progress note dated 6/29/21 Documented the following, "Resident dentures have been misplaced. RD met with the resident to discuss possible downgrade in food texture..." A nursing note dated 6/29/21 documented: "During initial admission upon assessment writer asked resident if she used dentures resident said 'yes', writer asked resident where is it resident said 'I lost them in the hospital.'" A social workers (SW) progress note dated 7/1/21 documented, "Spoke to resident sister...Sister is also upset about the missing dentures. Writer informed sister that writer will address her concern..." Resident #3's care plan was reviewed and did not evidence a care plan for the care and safeguard of Resident #3's dentures. On 12/14/21 at 9:00 AM, the director of nursing (DON) was interviewed regarding care planning of dentures. The DON stated that a care plan should have been completed for dentures, and information should be on the Treatment Administration Record (TAR) so the nurses can sign off that dentures were in place.	F 656		

On 12/14/21 at 9:45 AM, the DON stated the

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F 656	Continued From page 3 TARs had been reviewed and did not include dentures for the nurses to sign off. On 12/14/21 at 10:30 AM the above information was discussed with the DON and the administrator. No other information was presented prior to exit conference. This is a complaint deficiency.	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up	F 661	F661 Discharge Summary Resident #4 chart with the deficient practice discharged from the facility in October of 2020. A PIP process was implemented on 09/20/2021 to track the completion of discharge summaries. Process implemented to ensure that Discharge Summaries and History & Physical are completed for all residents within a timely manner. All discharge summaries have been under review since 9/20/2021. Audits will be conducted on all discharged patient charts weekly for the next 90 days by medical records manager. Findings will be reviewed each month during monthly QAPI meeting. Director of Nursing or designee will review findings with the Administrator for review with the QAPI Committee. Variances discovered in audit will be reviewed by the following members of the QAPI committee: (Medical Director or Designee, Director of Nursing, Dietician, Social Services Director, and Dietary Services Director) Plan of correction will be adjusted as	12/17/2021

	necessary dependent upon success of audits for achieving and maintaining compliance. Date of compliance 12/17/2021

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F 661	Continued From page 4 care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and in the course of a complaint investigation, the facility staff failed to ensure a discharge summary/recapitulation of stay was completed and documented by the physician for one of 4 residents in the survey sample, Resident #4. Findings include: Resident #4 was admitted to the facility on 04/06/2019 and discharged on 10/25/2020. Diagnoses for this resident included, but were not limited to: hypothyroidism, history of stroke, anxiety disorder, COVID-19, pneumonia, dementia with behaviors, history of UTI's (urinary tract infections), and stage 4 pressure ulcer. The most current MDS (minimum data set) was a significant change assessment dated 08/11/2020. This MDS assessed the resident with severe impairment in long- and short-term memory. The resident was also assessed as requiring extensive to total assistance from one to two staff member for all ADL's (activities of daily living). During the clinical record review, it was documented that the resident was discharged from the facility on 10/25/20 to the hospital for declining status. The resident did not return to the facility. There was no physician discharge summary was found in the Resident #4's clinical records. A "nursing" discharge summary was found. This discharge summary was dated 10/26/21 and	F 661	A PIP process was implemented on 09/20/2021 to document and implement a process to ensure that Discharge Summaries and History and Physical are completed for all residents, and that it is done in a timely manner. The process is monitored monthly in our QAPI Meeting and reported compliance are documented.	

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F 661	Continued From page 5	F 661		

timed 2:30 PM. The discharge summary was a fill in the blank/check the box type of document and was completed by an RN (Registered Nurse). The summary was not completely filled out, it did not document where Resident #4 was being discharged to, did not describe the mode of discharge, the reason for the discharge was described as, "other." A section of the discharge summary documented, "Nursing Recap...Course of treatment while in facility included complications." The form did not include pertinent information regarding Resident #4's stay and was not completed by the resident's physician.

On 12/14/21 at 9:00 AM, the DON (director of nursing) was asked for the physician discharge summary for Resident #4.

At approximately 9:15 AM, the DON stated that there was a discharge summary (referring to the one mentioned above). The DON was made aware that the above discharge summary was completed by an RN, not the physician and was incomplete. The DON stated that it should have been scanned into the electronic medical record and would look in the resident's closed paper chart.

At 10:20 AM, the DON stated that she could not find a discharge summary from the physician and presented the resident's closed paper chart. No discharge summary was found.

No further information and/or documentation was presented prior to the exit conference on 12/14/21 at 11:00 AM to evidence that the physician completed a discharge summary for Resident #4.

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