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 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (ARLINGTON)	550 SOUTH CARLIN SPRINGS ROAD ARLINGTON, VA 22204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced abbreviated Medicare/Medicaid survey was conducted at the facility on 05/04/2022. Two complaints were investigated during the survey. Complaint #VA00054983 was unsubstantiated with related deficient practice. Complaint #VA00054339 was unsubstantiated with no deficient practice. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 161 certified bed facility was 132 at the time of the survey. The survey sample consisted of three current resident reviews (Residents #1, #3, and #4) and one closed record review (Resident #2).	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and complaint investigation, the facility staff failed to implement their abuse policy for one of 4 residents in the survey sample, Resident #1. Facility staff failed to follow policy to report an	F 607		

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

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F 607	Continued From page 1	F 607		

allegation of abuse to the immediate attention of the administrator and/or director of nursing.

The findings include:

Resident #1 was admitted to the facility with diagnoses that included type 2 diabetes, vascular dementia without behavioral disturbance, chest pain, obstructive sleep apnea, hypertensive heart disease, gastro-esophageal reflux disease (GERD), hyperlipidemia, major depressive disorder, and chronic obstructive pulmonary disease (COPD).

The state agency received a facility reported incident (FRI) on 04/06/2022 alleging staff to resident abuse/mistreatment of Resident #1 occurred on 04/04/2022. The facility investigation documented the state agency, responsible party, physician, adult protective services, department of health professionals, and law enforcement were all notified on 04/06/2022, and notified again on 04/08/2022 with the completed full report of the investigation.

A review of the facility's investigation documented on 04/06/2022 Resident #1 was interviewed by the facility's previous administrator and a police officer in the resident's room. The statement was signed and dated by the administrator and Resident #1. The statement documented the follow questions and Resident #1's answers/replies:

"Question: Has anyone spoke to you rudely and spit in your face?"
"Answer: I can't recall anyone doing that."
"Question: "Do you feel safe here?"
"Answer: Yes"

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F 607	Continued From page 2	F 607		

"Question: Do you have any concerns?"
"Answer" No not at this time."

The facility's investigation included interviews with four employees having knowledge of the incident: certified nursing aide (CNA) #1, licensed practical nurse (LPN) #2, registered nurse (RN) #1, and LPN #1.

The 4/6/22 witness statement for LPN #2 who was working on the opposite end of the unit, documented that CNA #1 reported to her that Resident #1 scratched her. The witness statement documented LPN #2 told CNA #1 to inform the assigned nurse on the hall (RN #1) of the incident.

The 4/6/22 witness statement for RN #1 documented "I heard her talking about it on the hallway. I told her to talk with the unit manager about it."

The 4/7/22 witness statement for the unit manager (LPN #1) documented CNA #1 told LPN #1 that Resident #1 scratched her. LPN #1's witness statement documented that he asked CNA #1 to come to his office to complete an incident report.

On 05/04/2022 at 9:00 a.m., Resident #1 was interviewed and asked if she reported the incident to a nurse. Resident #1 stated, "Yes I told one of them later that day." Resident #1 was asked if she knew which nurse she reported the incident to. Resident #1 stated, "No, I don't know. But they know what happened." Resident #1 was asked if the nurse checked her for any bruises or scratches. Resident #1 stated, "Yes, she looked me over."

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F 607	Continued From page 3	F 607		

On 05/04/2022 at 1:30 p.m. the director of nursing (DON) was interviewed. The DON stated the nurse on duty (LPN # 4) failed to report the abuse allegation to the administrator, management, the physician, and the responsible party after Resident #1 self-reported the incident on 04/04/2022. The DON stated the nurse stated she forgot to notify the supervisor on 04/04/2022. The DON stated because LPN #4 forgot to notify management, the state agency was notified late. The DON stated LPN #4 was written up and counseled on the importance of reporting neglect, abuse or any complaints from a patient immediately. The DON was asked about the expectation for mandated reporting. The DON stated all nurses were trained and expected to immediately notify the management team including the house/on-call supervisor, administrator, DON, physician and, responsible party of any allegations of abuse.

A review of the counseling form documented, "employee failed to immediately report a resident's complaints to family, MD, and management. According to the employee (LPN #4), on 4/4/22, 3-11 shift, resident (Resident #1) reported to her that a CNA spat on her face and employee (LPN #4) reported this to her supervisor on 4/5/22. Employee (LPN #4) stated she forgot to notify the supervisor on 4/4/22." The counseling form documented LPN #4 received education on reporting neglect, abuse or any complaints from a patient immediately. Education documented the process that included removing the involved staff member from the resident and sending the staff member home immediately, and when reporting abuse to speak with a person and not leave a message.

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F 607	Continued From page 4 A review of the facility's policy titled "Patient Protection Abuse, Neglect, Mistreatment, and Misappropriation Prevention (10/2021) documented, "....(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriate of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials (including the State Survey Agency) and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures...." No additional information was received by the survey team prior to exit on 05/04/2022 at 3:30 p.m.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		

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F 609	Continued From page 5	F 609		

hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and complaint investigation, the facility staff failed to to report an allegation of abuse to the state agency in a timely manner for one of 4 residents in the survey sample, Resident #1.

The findings include:

Resident #1 was admitted to the facility with diagnoses that included type 2 diabetes, vascular dementia without behavioral disturbance, chest pain, obstructive sleep apnea, hypertensive heart disease, gastro-esophageal reflux disease (GERD), hyperlipidemia, major depressive disorder, and chronic obstructive pulmonary disease (COPD).

The state agency received a facility reported

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F 609	Continued From page 6	F 609		

incident (FRI) on 04/06/2022 alleging staff to resident abuse/mistreatment of Resident #1 occurred on 04/04/2022. The facility investigation documented the state agency, responsible party, physician, adult protective services, department of health professionals, and law enforcement were all notified on 04/06/2022, and notified again on 04/08/2022 with the completed full report of the investigation.

On 05/04/2022 at 9:00 a.m., Resident #1 was interviewed and asked if she reported the incident to a nurse. Resident #1 stated, "Yes I told one of them later that day." Resident #1 was asked if she knew which nurse she reported the incident to. Resident #1 stated, "No, I don't know. But they know what happened." Resident #1 was asked if the nurse checked her for any bruises or scratches. Resident #1 stated, "Yes, she looked me over."

On 05/04/2022 at 1:30 p.m. the director of nursing (DON) was interviewed. The DON stated the nurse on duty (LPN # 4) failed to report the abuse allegation to the administrator, management, the physician, and the responsible party after Resident #1 self-reported the incident on 04/04/2022. The DON stated the nurse stated she forgot to notify the supervisor on 04/04/2022. The DON stated because LPN #4 forgot to notify management, the state agency was notified late. The DON stated LPN #4 was written up and counseled on the importance of reporting neglect, abuse or any complaints from a patient immediately. The DON was asked about the expectation for mandated reporting. The DON stated all nurses were trained and expected to immediately notify the management team including the house/on-call supervisor,

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F 609	Continued From page 7 administrator, DON, physician and, responsible party of any allegations of abuse. A review of the facility's policy titled "Patient Protection Abuse, Neglect, Mistreatment, and Misappropriation Prevention (10/2021) documented, "....(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriate of resident property, are reported immediately, but not later then 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials (including the State Survey Agency) and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures...." No additional information was received by the survey team prior to exit on 05/04/2022 at 3:30 p.m.	F 609		