PRINTED: 05/20/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED	
			720.25	<u></u>		С
		495102	B. WING _		0	5/04/2022
NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSING AND REHAB (ARLINGTON)			STREET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH CARLIN SPRINGS ROAD ARLINGTON, VA 22204			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F 0	00		
F 607 SS=D	survey was conducted 05/04/2022. Two conduring the survey. Conduring the survey with no deficient practice of the conduction of the consisted for compliant Federal Long Term Conduction. The census in this 16:132 at the time of the consisted of three cutoff (Residents #1, #3, and review (Residents #1, #3, and review (Residents #2). Develop/Implement #2). Develop/Implement #2. Develop/Implement #2. Develop/Implement written postable of the conduction	applaints were investigated omplaint #VA00054983 was related deficient practice. 339 was unsubstantiated effice. Corrections are lice with 42 CFR Part 483 feare requirements. 31 certified bed facility was essurvey. The survey sample effect resident reviews and #4) and one closed record effect. Abuse/Neglect Policies (3) by must develop and efficies and procedures that: it and prevent abuse, tion of residents and esident property, sh policies and procedures	F6	07		
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUF	DE .	TITLE		(X6) 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. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: VA0155

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		495102	B. WING _			C 05/04/2022
	ROVIDER OR SUPPLIER	AND REHAB (ARLINGTON)		STREET ADDRESS, CITY, STATE, Z 550 SOUTH CARLIN SPRINGS R ARLINGTON, VA 22204		00/04/2022
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F 607	Continued From page	÷ 1	F 6	607		
		the immediate attention of /or director of nursing.				
	The findings include:					
	diagnoses that includ dementia without beh pain, obstructive slee disease, gastro-esoph (GERD), hyperlipiden disorder, and chronic disease (COPD). The state agency recincident (FRI) on 04/0 resident abuse/mistre occurred on 04/04/20 documented the state physician, adult prote of health professional were all notified on 04/04/20 documented the state physician, adult prote of health professional were all notified on 04/04/20 documented the state physician, adult prote of health professional were all notified on 04/04/20 documented the state physician, adult prote of health professional were all notified on 04/04/20 documented the state physician, adult prote of health professional were all notified on 04/04/20 documented the state physician, adult protection of the pain of the	_				
	on 04/06/2022 Reside the facility's previous officer in the resident' signed and dated by	ement documented the				
	"Question: Has anyor spit in your face?" "Answer: I can't recal "Question: "Do you fe "Answer: Yes"					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495102	B. WING _	····		C 05/04/2022	
	ROVIDER OR SUPPLIER	AND REHAB (ARLINGTON)	1	STREET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH CARLIN SPRINGS ROAD ARLINGTON, VA 22204	•		
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F 607	"Answer" No not at The facility's investifour employees have certified nursing aid nurse (LPN) #2, regular LPN #1. The 4/6/22 witness was working on the documented that Cl Resident #1 scratch statement documented the incident. The 4/6/22 witness documented "I hear hallway. I told her to about it." The 4/7/22 witness manager (LPN #1) #1 that Resident #1 witness statement of CNA #1 to come to incident report.	nave any concerns?"	F6	,			
	to a nurse. Residen them later that day. she knew which nur to. Resident #1 stat know what happene the nurse checked I	ted if she reported the incident to #1 stated, "Yes I told one of "Resident #1 was asked if the sees he reported the incident ed, "No, I don't know. But they ed." Resident #1 was asked if the for any bruises or the stated, "Yes, she looked"					

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		495102	B. WING _			C 05/04/2022	
NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSING AND REHAB (ARLINGTON)			STREET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH CARLIN SPRINGS ROAD ARLINGTON, VA 22204	•	05/04/2022		
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F 607	nursing (DON) was in the nurse on duty (LI abuse allegation to the management, the physical party after Resident; on 04/04/2022. The list she forgot to notify the DON stated becommangement, the state The DON stated LPN counseled on the impabuse or any complainmediately. The DO expectation for management all nurses were immediately notify the including the house/or administrator, DON, party of any allegation.	30 p.m. the director of interviewed. The DON stated PN # 4) failed to report the ne administrator, ysician, and the responsible #1 self-reported the incident DON stated the nurse stated he supervisor on 04/04/2022. A suse LPN #4 forgot to notify hate agency was notified late. If #4 was written up and portance of reporting neglect, hints from a patient DN was asked about the lated reporting. The DON he trained and expected to be management team con-call supervisor, physician and, responsible has of abuse.	F6				
	#4), on 4/4/22, 3-11 sreported to her that a employee (LPN #4) is supervisor on 4/5/22 she forgot to notify the counseling form doce education on reporting complaints from a particular documented the proof the involved staff messending the	s to family, MD, and ding to the employee (LPN shift, resident (Resident #1) a CNA spat on her face and eported this to her . Employee (LPN #4) stated he supervisor on 4/4/22." The tumented LPN #4 received high neglect, abuse or any tient immediately. Education hess that included removing her from the resident and her home immediately, and her to speak with a person and					

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F 607	Continued From page	÷ 4	F 6	07			
F 609 SS=D	Protection Abuse, Ne Misappropriation Prev documented, "(c) It abuse, neglect, exploit facility must: (1) Ensuinvolving abuse, neglemistreatment, includir source and misappro are reported immedia hours after the allegatin serious bodily injurif the events that cause involve abuse and do injury, to the Administ other officials (includiand adult protective sprovides for jurisdiction facilities) in accordance stablished procedure. No additional informa survey team prior to exp.m. Reporting of Alleged CFR(s): 483.12(c)(1) (1) (1) (2) (3) (1) (2) (3) (1) (3) (3) (1) (4) (4) (4) (1) (4) (4) (5) (1) (5) (1) (5) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	n response to allegations of itation, or mistreatment, the re that all alleged violations ect, exploitation or ng injuries of unknown priate of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result y, or not later than 24 hours se the allegation do not not result in serious bodily rator of the facility and to ng the State Survey Agency) ervices where state law on in long-term care be with State law through es" tion was received by the exit on 05/04/2022 at 3:30 Violations 4) se to allegations of abuse, or mistreatment, the facility that all alleged violations	F6	09			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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F 609	that cause the allegaserious bodily injury the events that cause abuse and do not rethe administrator of officials (including to adult protective serve for jurisdiction in lonaccordance with Staprocedures. §483.12(c)(4) Report investigations to the designated represer accordance with Stasurvey Agency, with incident, and if the appropriate corrective This REQUIREMENT by: Based on staff internand complaint invest to to report an allegate agency in a timely many in the survey sample. The findings include Resident #1 was addiagnoses that includementia without be pain, obstructive sledisease, gastro-esol (GERD), hyperlipide	ation is made, if the events ation involve abuse or result in or not later than 24 hours if the ethe allegation do not involve sult in serious bodily injury, to the facility and to other of the State Survey Agency and ices where state law provides geterm care facilities) in the law through established to the results of all administrator or his or her officials in the law, including to the State win 5 working days of the lleged violation is verified by action must be taken. This is not met as evidenced view, facility document review the tigation, the facility staff failed ation of abuse to the state manner for one of 4 residents ether that is not met 1.	F6	609			
	The state agency re	ceived a facility reported					

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PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
resident abuse/n occurred on 04/0 documented the physician, adult of health profess were all notified on 04/08/2022 with einvestigation. On 05/04/2022 a interviewed and to a nurse. Resident that dishe knew which to. Resident #1 sknow what happy the nurse checke scratches. Resident when the nurse on dutabuse allegation management, the party after Resident on 04/04/2022. The forgot to not The DON stated management, the The DON stated counseled on the abuse or any colimmediately. The expectation for mistated all nurses	04/06/2022 alleging staff to nistreatment of Resident #1 04/2022. The facility investigation state agency, responsible party, protective services, department ionals, and law enforcement on 04/06/2022, and notified again ith the completed full report of	F 60	09		

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F 609	A review of the facil Protection Abuse, N Misappropriation Prodocumented, "(c) abuse, neglect, expfacility must: (1) Eninvolving abuse, nemistreatment, inclus source and misappeare reported immediate that cause the allegtin serious bodily injuif the events that cainvolve abuse and cinjury, to the Admin other officials (incluand adult protective provides for jurisdict facilities) in accordate established procedu.	ity's policy titled "Patient Reglect, Mistreatment, and revention (10/2021) In response to allegations of Policitation, or mistreatment, the sure that all alleged violations glect, exploitation or ding injuries of unknown repriate of resident property, liately, but not later then 2 gation is made, if the events lation involve abuse or result larry, or not later than 24 hours luse the allegation do not do not result in serious bodily istrator of the facility and to ding the State Survey Agency) a services where state law through	F	609		