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 07/12/2023

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

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/10/2023 through 7/12/2023. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/10/2023 through 7/12/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 240 certified bed facility was 155 at the time of the survey. The survey sample consisted of 32 current resident reviews and 3 closed record reviews. Six complaints were investigated during the survey and are as follows: VA00058984 allegations were unsubstantiated without deficiencies cited. VA00057815 allegations were unsubstantiated without deficencies cited. VA00059120 allegations were unsubstantiated without deficencies cited. VA00056135 allegations were unsubstantiated without deficiencies cited. VA00057365 allegations were unsubstantiated without deficencies cited. VA00058614 allegations were unsubstantiated without deficencies cited.	F 000	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Regency Care of Arlington agrees with the allegations and citations listed on the statement of deficiencies. Regency Care of Arlington maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Regency Care of Arlington's written credible allegation of compliance. By submitting this plan of correction, Regency Care of Arlington does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Regency Care of Arlington reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tina Schilling
TITLE: Administrator
(X6) DATE: 8.4.23

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.

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 07/12/2023

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

(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 584 SS=D	Continued From page 1 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike 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 facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584 F 584	1. Resident #49 is in possession of all desired personal items at this time. 2. Residents relocating to alternate rooms in the facility and residents residing on 300 hall have the potential to be affected by this alleged deficient practice. 3. The Administrator has educated the social service department employees on confirming all desired personal belongings are received following room relocation and the maintenance and housekeeping department employees on completing necessary repairs and thoroughly cleaning resident furniture. This education was completed by 8/4/2023. Any social service, maintenance or housekeeping employee not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new hire orientation.	

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 07/12/2023

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

(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 584	Continued From page 2 §483.10(i)(7) For the maintenance of comfortable sound levels. This Requirement is not met as evidenced by: Based on observation, staff interviews, and chart review, the facility failed to maintain a clean, home-like environment for one resident, Resident #49, out of thirty-five residents in the survey sample, as well as for one of four units (300 unit) in the facility. The findings include: 1. Resident #49 (R49) did not have her personal items and clothing returned after a room change. R49 was admitted to the facility with diagnoses that included paraplegia, hypertension, gastroesophageal reflux disease, gastric ulcer, diabetes, COPD (chronic obstructive pulmonary disease), polyneuropathy, major depression disorder and anemia. The minimum data set (MDS) dated 5/4/23 assessed R49 as cognitively intact and to require the extensive assistance of two people for bed mobility, transfers, dressing and hygiene. On 7/10/23 at 12:00 p.m., R49 was interviewed about quality of life/care in the facility. R49 stated during this interview that she moved rooms "a couple of months ago" and many of her personal items were missing and had not been brought to her new room. R49 stated, "They lost all my personal items." R49 stated missing items included clothing, shoes, cosmetics, facial creams, family pictures and a purse. R49 stated the social worker was aware that she was missing the items and she had received no follow up about when the items would be returned. Resident #49 stated she did not want to lose her items, especially her family pictures, and that she	F 584	4. The Administrator/Designee will monitor resident room moves to validate personal items received, 300 hall resident room base boards are intact, 300 hall common area furniture for cleanliness and 300 hall resident bathroom floors for cleanliness weekly for 4 weeks then monthly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	8/4/23

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 07/12/2023

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

(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 584	Continued From page 3	F 584		

wanted to wear some of her summer clothes.

On 7/11/12 at 1:35 p.m., the certified nurses' aide (CNA #1) caring for R49 was interviewed. CNA #1 stated the resident moved from another floor and her personal items were packed in storage. CNA #1 stated the resident preferred to wear a gown in bed but wanted clothes on when she went to activities and/or appointments. CNA #1 was not sure if the resident was missing clothing or other personal items.

On 7/11/23 at 1:37 p.m., accompanied by the registered nurse unit manager (RN #3) and with R49's permission, the resident's room, dresser and closet were inspected. Several plastic containers beside the bed stored crafts and paper/pens but no clothing or pictures. There was one pair of sweatpants, a shirt, socks and a pair of shoes on top of the plastic containers. There were two fleece sweatsuits in the dresser. There were no other clothing or personal items in the dresser or in the resident's closet. The resident's cosmetics, creams and pictures were not located in the room. No summer clothing items were found other than the set on top of the plastic container. RN #3 was interviewed at this time about R49's belongings. RN #3 stated that R49's move from another floor was initially planned to be temporary because the room required maintenance/repair. RN #3 stated that R49's items and clothing were packed and placed in storage. RN #3 stated that R49 decided to stay in the new room. When questioned regarding R49's personal items not being returned, RN #3 stated "Somebody has dropped the ball."

On 7/11/23 at 3:45 p.m., the maintenance director (other staff #2) was interviewed about R49's belongings. The maintenance director stated that

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 07/12/2023

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

(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 584	Continued From page 4	F 584		

the resident moved floors due to renovations of the previous room. The maintenance director stated that R49 "...had too much stuff" and that most of the items were packed and placed in storage. The maintenance director stated that R49 was told when she moved that only the things she needed would be brought to the new room to reduce the clutter. The maintenance director stated R49's items were not lost but were packed in the storage room. The maintenance director stated the social worker was aware and he thought the family was going to assist the resident with selecting items for the new room.

On 7/12/23 at 9:53 a.m., the social worker (other staff #5) was interviewed about R49's clothing and personal items. The social worker stated the resident had "lots of items." The social worker stated prior to the room change, she had a conversation with R49 about not taking all the items to the new room. The social worker stated R49 had about "...ten boxes of stuff." The social worker stated that R49 had some of her things in the new room and the problem was going through the boxes with her to get out what she wanted and/or needed.

Resident #49's clinical record documented the resident moved to the current floor on 5/2/23.

This finding was reviewed with the administrator and director of nursing during a meeting on 7/11/23 at 4:30 p.m.

2. The 300 unit was observed to have several areas of persistant concern.

Findings include:

Observation on 07/10/23 at 2:37 PM, on 07/11/23

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 07/12/2023

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

(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 584	Continued From page 5 at 4:17 PM, and 07/12/23 at 10:33 AM revealed that the plastic base board was loose and fell off the wall in a 5-foot area in Room 305A's bathroom. The wall behind the base board was disintegrating. Observation on 07/10/23 at 2:28 PM, 07/11/23 at 7:50 AM and 4:17 PM and on 07/12/23 at 10:33 AM revealed that the upholstered seats on five of five wooden chairs in the TV lounge on the 3rd floor were soiled with white and brown substances. Three of the chair seats were soiled with what appeared to be a large, dried spot in the center of the seats. Observation on 07/10/23 at 2:28 PM, 07/11/23 at 7:50 AM and 4:17 PM and on 07/12/23 at 10:33 AM revealed a build up of brown substance on the floor around the base of the toilet in room 307's bathroom. On 07/12/23 at 10:33 AM, the Administrator, Maintenance Director and Housekeeping Director were present during each of the observations, and verified the findings. They stated that they were not aware of the environmental issues. Review of the undated facility policy titled "Maintenance and Housekeeping" stated, " ...the facility's maintenance and housekeeping departments will work to provide a safe, clean, comfortable, and homelike environment ...."	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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	F 609		

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 07/12/2023

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

(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 609	Continued From page 6 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation 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 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 interviews, record review, and policy review, the facility failed to ensure an allegation of abuse was reported to the Administrator and to the State Agency within two hours of the allegation being reported to facility staff. This involved one resident (R)84) in the sample of 35 residents. Findings include: During an interview on 07/10/23 at 12:30 PM, R84 stated that a male aide was rough with her during perineal care and had cursed at her. When asked if he hurt her, R84 stated he hurt her bottom. R84 stated it had occurred on the 3:00 PM to 11:00 PM shift and it has been ongoing. At	F 609	1. Resident #84 is safe and secure in the facility. 2. Residents in the facility have the potential to be affected by this alleged deficient practice. 3. The Staff Development Coordinator has educated facility employees on immediately reporting allegations of abuse or neglect to the facility Administrator once the resident has been deemed safe. This education was completed by 8/4/2023. Any employee not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new hire orientation.	

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 07/12/2023

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

(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 609	Continued From page 7 12:32 PM, the Unit Manager/Registered Nurse (RN)3 entered R84's room. R84 told the Unit Manager that the male aide on the evening shift was rough with her, that she did not want him caring for her, and that she preferred to have a female aide. On 07/10/23 at 3:22 PM, the resident was asked by the surveyor if she knew who was assigned to care for her on the 3:00 PM to 11:00 PM shift that evening. R84 answered that the same male aide had been assigned to her, and she was not happy about it. At 3:23 PM, Licensed Practical Nurse (LPN)2 was queried about which nursing assistants were assigned on the second shift. LPN2 stated that certified nursing assistant (CNA) 2 and CNA 3. CNA 2 met the description provided by R84 earlier. At 3:25 PM, CNA 2 and CNA 3 were both asked what residents they were assigned to, and both stated CNA 2 was assigned to care for R84. CNA 2 stated R84 was on his routine assignment. On 07/10/23 at 3:28 PM, the Unit Manager/RN 3 was asked what R84 had reported when she entered R84's room. RN 3 stated that R84 had reported that a male aide on the evening shift was rough during perineal care, she did not want him caring for her, and that she requested a female care giver. RN 3 stated that she was going to make sure R84 had a female CNA, however she had not yet gotten around to it. When questioned further, RN 3 stated that she had not told the Administrator what R84 had reported to her. During an interview on 07/10/23 at 4:06 PM, the Director of Nursing (DON) and the Administrator stated they had just been informed at 3:30 PM by RN 3 of R84's allegation that a male nursing	F 609	4. The Director of Nursing/ Assistant Director of Nursing will monitor allegations of abuse or neglect weekly for 4 weeks then monthly for 2 months to validate timely reporting to facility Administrator occurred. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	8/4/23

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 07/12/2023

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

(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 609	Continued From page 8	F 609		

assistant had been rough during peri care. The Administrator stated that RN3 told her she was looking into it and trying to figure out which male nursing assistant, since there were two male nurse aides working the 3:00 PM to the 11:00 PM shift. The Administrator stated that a resident stating an aide was rough during perineal care would be considered as abuse. The Administrator stated she had not been told about it until 3:30 PM after the surveyor queried RN 3 about it.

Interview on 07/10/23 at 4:33 PM, the RN 3 was interviewed with the Administrator present. RN 3 stated that at 12:30 PM, R84 told her CNA 2 was rough and she wanted a female aide. RN 3 stated that she did not report it to the Administrator because she did not consider it to be abuse and she was attempting to figure out which male nursing assistant R84 was talking about.

Review of R84's electronic medical record (EMR) under the "Minimum Data Set (MDS)" tab revealed R84's significant change "MDS" with an Assessment Reference Date (ARD) of 06/09/23 indicated R84 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating she was cognitively intact and required extensive assistance of one person for toilet use and personal hygiene.

Review of a "progress note" under the "progress note" tab of the EMR written by Unit Manager/RN3 dated 07/10/23 at 5:10 PM revealed, "Resident reports that the assigned male 3-11 CNA [certified nurse aide] is rough when providing peri care, causing soreness to her perineum, head to toe assessment performed no redness or excoriation noted to perineum no discoloration or bruises observed, denies discomfort at time of assessment."

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 07/12/2023

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

(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 609	Continued From page 9 Review of the facility's policy titled, "Regency Care of Arlington Resident Abuse" dated 05/03/17 revealed the facility's definition of abuse included "...causing physical pain or injury." The policy stated, " ... reported allegations or suspected abuse must be reported to the Administrator, other officials in accordance with State law, and the State Survey and Certification agency within 2 hours after the allegation is made. "	F 609		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623	1. Resident's #84 and #135 have not transferred or discharged since the survey exit date. Resident #358 no longer resides in the facility. 2. Residents in the facility have the potential to be affected by this alleged deficient practice.	

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 07/12/2023

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

(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 623	Continued From page 10 this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental	F 623	3. The Staff Development Coordinator has educated Licensed Nurses on providing written notice of transfer/ discharge to residents and/or their responsible party when required. The Administrator has educated the Social Service department employees on providing a list of transfers and discharges to the Ombudsman at least monthly. This education was completed by 8/4/2023. Any Licensed Nurse or Social Service employee not receiving this information by this date will receive prior to next scheduled shift. This information will be presented in new hire orientation.	

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 07/12/2023

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

(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 623	Continued From page 11 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This Requirement is not met as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure three of three residents and their representatives (Resident (R) 358, R84 and R135) reviewed for facility initiated emergent hospital transfer were provided with written transfer/discharge notice that stated the reason for transfer, the place of transfer, and other information regarding the transfer. This failure had the potential to adversely affect the residents and their Resident Representatives (RR) by not having the knowledge of where and why a resident was being transferred, and/or how to appeal the transfer, if desired, as well as preventing the State LTC Ombudsman from identifying inappropriate discharges.	F 623	4. The Medical Records Director/Designee will monitor resident transfers and discharges for provision of written notice weekly for 4 weeks then monthly for 2 months. The Administrator will monitor Ombudsman notification of transfers and discharges monthly for 3 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	8/4/23

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 07/12/2023

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

(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 623	Continued From page 12	F 623		

Findings include:

Review of the facility's policy titled, "Transfer and Discharge (including AMA)" dated 2022 provided by the Administrator, revealed the facility will provide a notice of transfer to the resident and representative as indicated. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman."

1. Review of R358's "Diagnosis" tab in the electronic medical record (EMR) revealed R358 was admitted on 02/10/23 with a non-operable fracture of the left humerus, fusion of the cervical spine, and a history of falling.

Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/23/23 revealed R358 had a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating no cognitive impairment.

Review of a "nursing progress note" dated 05/29/23 at 9:10 AM revealed R358 was sent to the hospital's emergency department (ED) due to an unwitnessed fall during the night.

Review of R358's EMR revealed no documentation that a written notice of transfer/discharge was sent to R358, R358's responsible party, or the Ombudsman.

2. Review of R135's "Diagnosis" tab in the EMR revealed R135 was admitted 01/06/23 with diagnoses of hypertensive chronic kidney disease, Type II Diabetes Mellitus, and generalized muscle weakness.

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 07/12/2023

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

(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 623	Continued From page 13	F 623		

Review of R135's admission "MDS" with an ARD of 01/13/23 revealed a BIMS of 09, indicating moderate cognitive impairment.

Review of a "nursing progress note" dated 03/14/23 at 8:16 PM revealed R135 was sent to the hospital's ED due to an unwitnessed fall with head injury.

Review of R135's EMR revealed no documentation that a written notice of transfer/discharge was sent to R135, R135's responsible party, or the Ombudsman.

3. Interview on 07/13/23 at 2:53 PM, R84 stated that she was sent to the hospital not too long ago because her knee was swollen, and she was sick. When asked if she received a written transfer notice, she stated that she could not remember.

Review of R84's EMR "Diagnosis" tab revealed diagnoses of Methicillin Resistant Staphylococcus Aureus (MRSA) and inflammatory reaction due to internal left knee prosthesis.

Review of R84's significant change "MDS" with an ARD of 06/09/23 revealed a BIMS score of 13 out of 15 indicating R84 was cognitively intact.

Review of a "nursing progress note" dated 05/14/29 at 11:48 PM, indicated resident had emesis with coffee ground color. The doctor was notified, and the resident was sent to the hospital ED for evaluation.

Review of a "nursing progress note" dated 05/15/23 at 6:39 AM indicated the resident was admitted to the hospital with a diagnosis of sepsis.

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 07/12/2023

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

(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 623	Continued From page 14 Review of R84's EMR revealed no documentation that a written notice of transfer/discharge was sent to R84, R84's responsible party, or the Ombudsman. During an interview on 07/12/23 at 10:50 AM, the Administrator revealed that the facility did not provide written transfer notices or contact the Ombudsman concerning emergent transfers of the residents to the hospital.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy	F 625	1. Resident's #84 and #135 have not transferred or discharged since the survey exit date. Resident #358 no longer resides in the facility. 2. Residents in the facility have the potential to be affected by this alleged deficient practice.	

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 07/12/2023

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

(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 625	Continued From page 15 described in paragraph (d)(1) of this section. This Requirement is not met as evidenced by: Based on record review, interview, and review of facility policy, the facility failed to ensure three of three residents (Resident (R) 358, R84 and R135) reviewed for facility initiated emergent transfer to the hospital and/or their Resident Representative (RR) received a written bed hold notice that included all required information from a sample of 35 residents. This failure had the potential to contribute to possible denial of re-admission and loss of the resident's home following a hospitalization. Findings include: Review of the facility's policy titled, " Transfer and Discharge (including AMA)" dated 2022 provided by the Administrator, revealed that the facility will provide the facility's bed hold policy to the resident and representative as indicated. Review of the facility's policy titled, "Bed Hold Notice Upon Transfer" dated 2022 provided by the Administrator, revealed: 1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and /or the resident representative written information that specifies: a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility. b. The reserve bed payment policy in the state plan policy, if any. c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. d. Conditions upon which the resident would return to the facility:	F 625	3. The Staff Development Coordinator has educated Licensed Nurses on providing written notice of facility bed hold rates to residents and/or their responsible party when required. This education was completed by 8/4/2023. Any Licensed Nurse or not receiving this information by this date will receive prior to next scheduled shift. This information will be presented in new hire orientation. 4. The Business Office Manager /Designee will monitor resident transfers and discharges for provision of written notice of bed hold rates weekly for 4 weeks then monthly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	8/4/23

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 07/12/2023

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

(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 625	Continued From page 16 o the resident requires the services which the facility provides. o the resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. 2. In the event of an emergency transfer of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan. Review of a facility policy titled, "Regency Care of Arlington - BED HOLD POLICY AND PROCEDURE" provided by the Administrator revealed, "Federal Law Requires that this statement be given to each resident upon discharge for a hospitalization or a therapeutic leave." 1. Review of R358's "Diagnosis" tab in the electronic medical record (EMR) revealed R358 was admitted on 02/10/23 with a non-operable fracture of the left humerus, fusion of the cervical spine, and a history of falling. Review R358's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/23/23 revealed R358 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating no cognitive impairment. Review of a "nursing progress note" dated 05/29/23 at 9:10 AM revealed R358 was sent to the hospital's emergency department (ED) due to an unwitnessed fall during the night. 2. Review of R135's "Diagnosis" tab of the EMR revealed that R135 was admitted on 01/06/23 with hypertensive chronic kidney disease, Type II Diabetes Mellitus, and generalized muscle weakness.	F 625		

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 07/12/2023

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

(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 625	Continued From page 17	F 625		

Review of R135's Admission "MDS" with an ARD of 01/13/23 for R135 revealed he had a BIMS of 09 out of 15, indicating moderate cognitive impairment.

Review of a "nursing progress note" dated 03/14/23 at 8:16 PM revealed R135 was sent to the hospital's ED due to an unwitnessed fall.

Review of R135's EMR revealed no documentation of a written notice of bed hold being sent to the R135 and/or R135's responsible party.

3. Interview on 07/13/23 at 2:53 PM, R84 stated she was sent to the hospital not too long ago because her knee was swollen, and she was sick. When asked if she received a written bed hold notice, she stated not that she could remember.

Review of R84's EMR under the "medical diagnosis" revealed her diagnosis included Methicillin Resistant Staphylococcus Aureus (MRSA) and inflammatory reaction due to internal left knee prosthesis.

Review of R84's significant change "MDS" assessment with an ARD of 06/09/23 revealed R84 had a BIMS score of 13 out of 15 indicating she was cognitively intact.

Review of a "nursing progress note" dated 05/14/29 at 11:48 PM stated R84 had coffee ground colored emesis. The doctor was notified, and R84 was sent to the hospital's ED for evaluation.

Review of a "nursing progress note" dated 05/15/23 at 6:39 AM stated the resident was

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 07/12/2023

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

(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 625	Continued From page 18 admitted to the hospital with a diagnosis of sepsis. Review of R84's EMR revealed no documentation that a written notice of bed hold was sent to R84 and/or R84's responsible party. During an interview on 07/12/23 at 10:50 AM, the Administrator revealed that the facility did not provide written bed hold notices to the residents and/or their representatives with emergent transfers to the hospital.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This Requirement is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to complete an accurate minimum data set (MDS) for two of thirty-five residents in the survey sample (Residents #129 and #359). The findings include: 1. Resident #129's MDS dated 7/5/23 failed to accurately assess the resident's actual dental problems. Resident #129 (R129) was admitted to the facility with diagnoses that included quadriplegia, respiratory failure, neurogenic bladder, anemia, anxiety, history of pulmonary embolism, pressure ulcers and depression. The minimum data set (MDS) dated 7/5/23 assessed R129 as cognitively intact. On 7/10/23 at 3:15 p.m., R129 was interviewed	F 641	1. Resident's #129's minimum data set section L was modified to reflect accurate information. Resident #359 no longer resides in the facility and the discharge minimum data set section M was modified to reflect accurate information. 2. Residents with dental issues and skin impairment have the potential to be affected by this alleged deficient practice. The corporate Director of Reimbursement has reviewed Minimum Data Sets completed within the past 30 days specific to section(s) L and M to validate accurate information is coded. All concerns identified were addressed at time of discovery.	

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 07/12/2023

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

(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 641	Continued From page 19 about quality of care in the facility. R129 stated during this interview that she was missing all but her front upper teeth and that she had tooth decay. R129 then displayed her front teeth. The teeth were dark around the edges with broken, jagged surfaces. R129 was missing the upper back and lower teeth. Resident #129's clinical record documented an oral assessment dated 6/13/23 indicating that R129 had broken, decayed, and missing teeth. Section L0200 of R129's MDS dated 7/5/23 documented that the resident had no dental problems. The category to indicate obvious or likely cavities or broken natural teeth was not marked. Item Z. was erroneously marked indicating no oral/dental problems. On 7/12/23 at 8:00 a.m., the registered nurse MDS coordinator (RN #4) was interviewed about R129's MDS assessment indicating no dental problems. RN #4 reviewed the clinical record and stated the resident's oral assessment completed on 6/13/23 indicated broken, decayed teeth. RN #4 stated the 7/5/23 MDS should have indicated that R129's broken, decayed, and missing teeth. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual on pages L-1 and L-2 documents regarding oral/dental assessment, "...This item is intended to record any dental problems present in the 7-day look-back period...Check L0200D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen..." (1) This finding was reviewed with the administrator and director of nursing during a meeting on 7/12/23 at 12:45 p.m.	F 641	3. The corporate Director of Reimbursement has educated the Resident Assessment Coordinators on proper coding of sections L and M of the minimum data set per the RAI manual specifications. This education was completed by 8/4/2023. This information will be presented in new hire orientation. 4. The Director of Nursing/ Assistant Director of Nursing will monitor resident minimum data sets section(s) L and M for accuracy monthly for 3 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	8/4/23

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 07/12/2023

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

(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 641	Continued From page 20 (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, Centers for Medicare & Medicaid Services, Revised October 2019. 2. Review of R359's electronic medical record (EMR) discharge return not anticipated "Minimum Data Set (MDS)"with an Assessment Reference Date (ARD) of 01/13/23 in the "MDS" tab revealed the MDS was coded that R359 did not have any pressure ulcers at the time of discharge under section M. Review of R359's "Specialty Physician Wound Evaluation and Management Summary" dated 01/11/23 under the "Miscellaneous" tab of the EMR revealed R359 had an unstageable necrosis pressure wound measuring 5.7 centimeter (CM) by 6 cm by 0.1 cm. During an interview on 07/11/23 at 2:15 PM, the MDS was reviewed with the Assistant Director of Nursing (ADON), who verified R359 had the pressure ulcer on 01/13/13 when she was discharged from the facility. The ADON verified that the discharge MDS was inaccurately coded for pressure ulcers.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656	1. Resident #3 does not currently reside in the facility.	

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 07/12/2023

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

(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 656	Continued From page 21 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). (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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This Requirement is not met as evidenced by: Based on observation, record review, interview, and review of facility policy, the facility failed to develop care plan interventions for one resident (Resident #3) from a sample of 35 residents.	F 656	2. Residents with suprapubic catheters have the potential to be affected by this alleged deficient practice. The nurse managers have reviewed resident care plans pertaining to suprapubic catheters to validate care interventions are present. All concerns identified were addressed at time of discovery. 3. The corporate Director of Reimbursement has educated the Resident Assessment Coordinators on including care interventions for suprapubic catheter plans of care when completing the Care Area Assessments (CAA). This education was completed by 8/4/2023. This information will be presented in new hire orientation.	

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 07/12/2023

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

(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 656	Continued From page 22 Resident #3 (R3) had physician's orders for care of his suprapubic catheter site but no interventions were care planned for this device. This failure has the potential for the resident not to receive the proper care of his catheter. Findings include: Review of the facility's policy titled "Comprehensive Care Plans" with an October 2022 revision date reads in part, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident's rights that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental psychosocial needs that are identified in the resident's comprehensive assessment." During an observation of morning care on 07/11/23 at 10:30AM, R3 was observed to have a suprapubic catheter draining cloudy urine with heavy sediment to a bedside bag. R3 did not have a dressing covering the suprapubic catheter site. Review of R3's "Admission Record" located in the electronic medical records (EMR) under "Medical Diagnosis" tab revealed R3 was admitted to the facility on 05/08/23. Review of R3's "Admission Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/12/23 located in R3's EMR under the "MDS" tab revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated severe cognitive impairment. This MDS further assessed R3 to be dependent on the staff for all activities of daily living, as well as having a suprapubic catheter.	F 656	4. The Unit Managers will monitor care plans for residents with suprapubic catheters to validate care interventions are present monthly for 3 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	8/4/23

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 07/12/2023

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

(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 656	Continued From page 23 Review R3's July 2023 "Physicians Orders" in the resident's EMR under the "Orders" tab revealed orders to clean the suprapubic catheter site with wound cleanser and apply dry dressing daily on 11-7 shift. Review of R3's "Care Plan" with a revision date of 06/02/23, located in the resident's EMR under the "Care Plan", revealed the interventions for the resident's suprapubic catheter included the following: position catheter bag and tubing below the level of the bladder; check tubing for kinks each shift; monitor and document intake and output as per facility policy; monitor for signs and symptoms of discomfort on urination; monitor and document discomfort due to catheter; monitor and report any signs or symptoms of urinary tract infection. However, the interventions did not include the physician's order to clean the catheter site and cover it with a dressing. During an interview on 07/12/23 at 08:38 AM, the Unit Manager Registered Nurse (RN)5 revealed that all nurses were responsible for developing and updating the resident's care plans with interventions. RN 5 stated that she developed the care plan interventions for R3's suprapubic catheter. RN 5 further stated that interventions should have included the physicians' orders to cleanse the catheter site and cover it with dressing.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690	1. Resident #3 does not currently reside in the facility.	

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 07/12/2023

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

(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 690	Continued From page 24 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This Requirement is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to provide appropriate suprapubic catheter care and handling for one resident (Resident # 3) from a sample of 35 residents. This failure increases the potential for R3 to develop recurring urinary tract infections (UTIs) or other complications. Findings include:	F 690	2. Residents with urinary catheters have the potential to be affected by this alleged deficient practice. 3. The Staff Development Coordinator has educated the Certified Nursing Assistants on appropriate placement of urinary catheter tubing and bags to facilitate drainage without backflow and on replacing catheter bag should it fall to floor and the Licensed Nurses on completing physician orders for dry dressings to suprapubic catheter sites. This education was completed by 8/4/2023. Any Certified Nursing Assistant or Licensed Nurse not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new hire orientation.	

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 07/12/2023

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

(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 690	Continued From page 25 Review of the facility's policy titled "Catheter Care-Suprapubic" dated October 2022 reads in part " ...Ensure drainage bag is located below the level of the bladder to discourage backflow of urine ...Suprapubic catheter care will be performed every shift and as needed by nursing personnel." Observation on 07/11/23 at 10:30AM revealed R3 receiving morning care. R3 was positioned on his back in bed. The catheter tubing was secured to R3's right thigh area with a leg strap. The catheter site did not have a dressing covering it. Certified Nursing Assistant (CNA) 6 and CNA8 were providing care to this resident. CNA 6 held the catheter drainage bag above the level of R3's bladder and then proceeded to empty the drainage bag, placing the drainage bag in the bed with the resident. However, there was still cloudy urine with sediment present in the tubing, which backed towards R3's bladder. After CNA8 wiped the suprapubic catheter, R3 was turned from side to side to clean his buttocks. While turning the resident, the drainage bag fell to the floor and remained there until the CNAs had completed R3's care and positioned him on his back again. Review of R3's "Admission Record" located in the electronic medical records (EMR) under "Medical Diagnosis" tab revealed R3 was admitted to the facility on 05/08/23 with the diagnosis of sepsis. Review of R3's "Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/12/23" located in the resident's EMR located under the "MDS" tab revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated R3 was severely cognitively impaired. This MDS also assessed R3 as being dependent on the staff for all activities of	F 690	4. The Unit Managers will randomly observe resident care to validate appropriate urinary catheter placement and confirm the presence of dry dressing if ordered 2 times per week for 4 weeks then weekly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	8/4/23

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 07/12/2023

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

(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 690	Continued From page 26	F 690		

daily living, as well as having a suprapubic catheter.

Review of R3's "Physicians Orders" for the month of July located in the EMR under the "Orders" tab revealed orders to clean the suprapubic catheter site with wound cleanser and apply dry dressing daily on 11-7 shift.

Review of R3's "Urinalysis and Urine Culture Report" located in the EMR under the "Results" tab revealed a urinalysis and urine culture report dated 06/28/23, which identified a urinary tract infection of proteus mirabilis - carbapenem resistant organism. This pathogen is common cause of cather-associated infections and can quickly progress into infections of the kidneys & blood stream.(1)

During an interview on 07/11/23 at 11:00 AM, CNA 8 stated that she had been trained to empty the catheter drainage bag before placing it in the bed with the resident. CNA 8 stated that she was not aware there was still urine in the tubing, potentially backing into the resident's bladder. CNA8 stated the urine backing into the resident's bladder could lead to reoccurring UTIs. CNA8 stated she was aware the drainage bag had fallen to the floor and the resident should receive a new drainage bag.

During an interview on 07/11/23 at 11:10 AM,CNA 6 stated that he knows to empty the drainage bag before placing it in the bed with the resident, but did not see the urine that remained in the tubing.

Interview on 07/11/23 at 11:27 AM, the Assistant Director of Nursing (ADON) and Unit Manager Registered Nurse (RN)5 stated that staff should have ensured the urine was completely drained

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 07/12/2023

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

(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 690	Continued From page 27 from the tubing and the bag before placing the bag in the bed with the resident while turning. Both agreed that the urine backing up into the resident's bladder can contribute to reoccurring UTIs. When questioned further, neither the ADON nor RN 5 were aware of the active physicians' order to clean R3's suprapubic catheter site with wound cleanser and apply dry dressing daily on 11-7 shift. 1. National Institutes of Health https://www.ncbi.nlm.gov>articles>PMC4638163	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This Requirement is not met as evidenced by: Based on observation, interviews, record review,	F 693	1. Resident #3 does not currently resident in the facility. 2. Residents with gastric feeding tubes have the potential to be affected by this alleged deficient practice.	

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 07/12/2023

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

(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 693	Continued From page 28 and review of facility policy, the facility failed to ensure that one resident (Resident #3) from a sampled 35 residents was properly positioned while receiving gastrostomy tube feeding. This failure has the potential for the resident to develop aspiration problems from the tube feeding. Finding include: Review of the facility's policy titled "Care and Treatment of Feeding Tube" dated October 2022 reads in part "The resident's plan of care will direct staff regarding proper positioning of the resident consistent with the resident's individual needs. Review of the facility's policy titled "Flushing a Feeding Tube" dated October 2022 reads in part "Prevent aspiration risk by keeping the head of bed elevated at a minimum of 30 degrees." Observation on 07/11/23 at 10:30AM of morning care revealed R3 in bed with the head of the bed (HOB) elevated less than 20 degrees, with the tube feeding infusing. While providing care the two Certified Nursing Assistants (CNA)6 and CNA 8 lowered the head of the R3's bed. R3's tube feeding continued to infuse while in this lower position. While in the lower position, R3 coughed a couple of times and the ventilator alarm sounded. The Respiratory Therapist entered the room and elevated R3s head to 35 degrees and suctioned the resident. Review of R3's "Admission Record" located in the electronic medical records (EMR) under "Medical Diagnosis" tab revealed R3 was admitted to the facility on 05/08/23 with the following diagnoses of sepsis, acute and chronic respiratory failure,	F 693	3. The Staff Development Coordinator has educated the Certified Nursing Assistants on appropriate positioning of residents with gastric feeding tubes specific to head of bed level to prevent aspiration while enteral nutrition is infusing. This education was completed by 8/4/2023. Any Certified Nursing Assistant not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new hire orientation. 4. The Unit Managers will randomly observe care of residents with gastric feeding tubes to validate appropriate positioning is maintained to prevent aspiration 2 times per week for 4 weeks then weekly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	8/4/23

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 07/12/2023

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

(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 693	Continued From page 29	F 693		

ventilator dependent, and dysphagia.

Review of R3's "Admission Minimum Data Set" (MDS) with an Assessment Reference Date of 05/12/23 located under the "MDS" tab revealed a Brief Interview for Mental Status score of zero out of 15, indicating severely impaired cognition. This MDS assessed R3 to be dependent on staff for all activities of daily living, as well as requiring enteral feeding through a gastrostomy to maintain his nutritional status.

Review of R3's July 2023 "Physicians Orders" located under the "Orders" tab revealed ...Always elevate HOB 30-45 degrees when in bed every shift. May interrupt tube feeding for medication administration and nursing care as needed."

Review of R3's "Care Plan" with a revision date 6/2/23 located under the "Care Plans" tab revealed that the interventions for the tube feeding included to keep HOB elevated 30-45 degrees during tube feed administration.

During an interview on 07/11/23 at 11:00 AM, CNA8 revealed that she was not sure of how many degrees the HOB should be when a resident is receiving tube feeding. When questioned further, CNA8 then stated she thought it should not be any lower than 35 degrees. Then she stated that she did not feel the HOB was that low.

During an interview on 07/11/23 at 11:10 AM, CNA 6 revealed that he did not know what position the head of bed should be in for residents receiving tube feeding.

During an interview on 07/11/23 at 11:27 AM, the Assistant Director of Nursing (DON) revealed that

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 07/12/2023

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

(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 693	Continued From page 30 residents receiving tube feedings should have the HOB elevated at between 35 to 45 degrees. The DON also stated that when the CNA's were providing care to the residents on tube feeding, they are expected to notify the nurse so the tube feeding can be put on hold, until the care is completed. During an interview of 07/12/23 at 08:38 AM, the Unit Manager Registered Nurse (RN)5 revealed that any resident receiving tube feeding should have the HOB elevated at all times. RN 5 further stated that it is an expectation for the CNAs to notify the nurse when giving care, so the tube feeding can be held during the care.	F 693		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This Requirement is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a medication error rate of less than five percent. Medication pass observations revealed two errors out of thirty-four opportunities resulting in a 5.8% error rate. The findings include: 1. On 7/11/23 at 8:00 a.m., a medication pass observation was conducted with licensed practical nurse (LPN #2) administering medications to Resident #134 (R134). Included in the medications administered to R134 was Senna Plus 8.6/50 milligrams (mg).	F 759	1. Residents #91 and #134 are receiving medications as ordered by the physician. 2. Residents in the facility have the potential to be affected by this alleged deficient practice.	

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 07/12/2023

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

(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 759	Continued From page 31 R134's clinical record documented a physician's order dated 6/19/23 for Senna 8.6 mg once per day for bowel management. R134 had no order for the Senna Plus 8.6/50 mg administered during the observed medication pass. On 7/11/23 at 9:25 a.m., LPN #2 was interviewed about the Senna Plus administered to R134. LPN #2 reviewed the orders and stated the order was for plain Senna and not Senna Plus, which included a stool softener. LPN #2 stated both senna products were from house stock and were available in the medication cart. This finding was reviewed with the administrator and director of nursing during a meeting on 7/11/23 at 4:30 p.m. with no further information provided about the medication error prior to the end of the survey. 2. Resident #91 was given Vitamin C 500 milligrams (mg) instead of physician ordered combination medication of iron and Vitamin C medication. The Findings Include: On 09/27/22 at 9:00 AM a medication pass and pour observation was conducted. License practical nurse (LPN) #1 began pulling medications out of the medication cart for Resident #91 and handing the medications to this surveyor to document. One of the medications pulled from the medication cart was Vitamin C 500 MG. LPN #1 dispensed the Vitamin C into the medication cup and gave it to Resident #91. Physician's orders were then reviewed to verify accuracy of medications given. There was a physician's order to give "Iron-Vitamin C Tablet	F 759	3. The Staff Development Coordinator has educated Licensed Nurses on administering medications as ordered by the physician. This education was completed by 8/4/2023. Any Licensed Nurse not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new hire orientation. 4. The Staff Development Coordinator/Designee will randomly observe Licensed Nurses administering medications to validate orders are followed 2 times per week for 4 weeks then weekly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	8/4/23

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 07/12/2023

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

(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 759	Continued From page 32 65-125 MG" (a combination medication) for anemia. On 7/11/23 at 9:21 AM LPN #1 was interviewed regarding the discrepancy. LPN #1 reviewed the order and then looked in the medication cart for the proper medication but could not find it. LPN #1 verbalized that she thought she had given the correct medication and thought that it was only a Vitamin C tablet. On 7/11/23 at 4:29 PM the above information was presented to the director of nursing (DON) and administrator. No other information was presented prior to exit on 7/12/23.	F 759		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This Requirement is not met as evidenced by:	F 812	1. No residents cited. 2. Residents receiving oral intake have the potential to be affected by this alleged deficient practice.	

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 07/12/2023

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

(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 812	Continued From page 33 Based on observation, interviews, and record review, review of facility policies, the facility failed to ensure food was stored, prepared, and maintained in accordance with professional standards for food service safety. a sanitary manner. This failure had the potential to affect 136 of 155 residents in the facility who consumed food from the kitchen. Findings include: Review of the facility's policy titled, "Food Safety Requirements" dated 2023 revealed "... food should be labeled and dated. Foods should be used by its use-by date or discarded." Review of the facility's policy titled, "Date Marking for Food Safety" dated 2023 revealed "... food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The individual opening the food shall be responsible for dating the food item when it is opened." Review of the facility's policy titled, "Use and Storage of Food Brought in by Family and Visitors" dated 2023 revealed "... food items brought in by family or visitors must be labeled with content and dated. The facility will store the food in the nourishment refrigerator and food not consumed within three days will be thrown away." 1. Observation on 07/10/23 at 11:41 AM of the refrigerator in the fifth-floor kitchenette with the Dietary Manager (DM) revealed the following food items in the refrigerator were either not labeled, not dated, or were past the use-by date: A 12-ounce Styrofoam cup of a white substance A dinner plate of fruit that was loosely covered	F 812	3. The Registered Dietician has educated the dietary employees on dating, discarding and storing resident food items as required in both the facility kitchen and unit kitchenette. This education was completed by 8/4/2023. Any dietary employee not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new hire orientation. 4. The Certified Dietary Manager /Designee will monitor unit kitchenettes and the facility kitchen for dating, discarding and storage of resident food items 2 times per week for 4 weeks then weekly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	8/4/23

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 07/12/2023

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

(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 812	Continued From page 34 with plastic wrap and appeared to be half eaten. An open 8-ounce container of milk Two 1.5-quart containers of melted churned ice cream. The ice cream containers were in a plastic style grocery bag. A plastic container of what appeared to be Chinese food. A plastic container of rice. A brown substance wrapped in aluminum foil. A container of chicken rice and green beans which appeared to be partially eaten. An open container of "Lyons" brand nectar thick water with a use-by date of 06/28/23. Three unopened containers of "Lyons" brand nectar thick liquid with use-by date of 06/28/23. A half-gallon plastic container of tea. A plastic container of unidentified food. The DM was present and verified each of these findings. The DM stated that they should have been dated, labeled, and discarded within 72 hours of opening and/or placing them in the refrigerator. The DM also stated that the refrigerator was supposed to be used only for resident food items. 2. Observation on 07/10/23 at 12:00 PM, the fourth-floor refrigerator contained two 32-ounce containers of nectar thick water with a use by date of 04/02/23 and one 32 ounce-container of honey thick water with a use by date of 01/04/23. The DM verified the observation and stated that the items should have been discarded after the use by date. 3. Observation on 07/10/23 at 12:05 PM of the third-floor resident refrigerator/freezer located in the third-floor kitchenette contained the following undated, unlabeled food items:	F 812		

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 07/12/2023

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

(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 812	Continued From page 35	F 812		

A plastic quart size container of an unidentified food item. The container had no name or date. There was a one-inch area of green furry mold on the top of the food item.

A quart size bag of grapes.

A container of rice and meat with R122's name written on it. The container was covered in foil and was not dated. Mold was growing on the top of the food.

The bottom of the refrigerator was soiled with a brown substance.

The freezer located over the refrigerator contained:

A glass container of a red substance and two containers of food with no name or date.

A 4-ounce container of yogurt with a use by date of 05/23/23.

A paper on the front of the refrigerator directed staff to date and label all food items with resident's names and that all food would be discarded after 72 hours.

The DM was present and verified each of these findings. The DM stated that the items should have been dated, labeled, and discarded within 72 hours of opening and/or placing them in the refrigerator. The DM again stated that the refrigerator was supposed to be used only for resident food items.

4. Observation on 07/10/23 at 11:30 AM and on 07/11/23 at 12:32 PM the following items were

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 07/12/2023

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

(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 812	Continued From page 36 observed being stored on a shelf under the food preparation counter in the dietary department: A one-half full 32-ounce bottle of lemon juice. A one-half full 5-pound bottle of Teriyaki glaze. A gallon jug of Sugarman maple syrup. The jug had been opened; was three-fourths full; and had a best by date of 12/18/22. A gallon jug of Gordon Choice soy sauce. The container only had about one cup of soy sauce left in it. None of the items were dated with the date they were opened. Review of the manufacturer's instructions on each of the products stated to "Refrigerate after opening." On 07/11/23 at 12:32 PM, the DM and Cook 1 verified each of the products had been opened and partially used; none of the products were dated with the date they were opened; each of the products were supposed to be refrigerated after being opened; and the maple syrup was past its best by date. The DM and Cook1 stated they had never put the food products in the refrigerator after they were opened because they were not aware that they needed to be refrigerated. The DM stated the items should have been dated with the date they were opened.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

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 07/12/2023

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

(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 880	Continued From page 37 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880	1. Residents #63, #75 and #122 are receiving meals trays by staff performing adequate hand hygiene. Resident #411 no longer resides in the facility. Resident #3 does not currently reside in the facility. Resident #139 has correct signage posted reflecting current transmission based precautions. Residents #86, #103, #133, #409, #412, #413, #414, #415 and #34are not identified on the resident sample list. 2. Residents in the facility have the potential to be affected by this alleged deficient practice. 3. The Infection Preventionist has educated all employees on donning and doffing of Personal Protective Equipment (PPE) in conjunction with Transmission Based Precautions, the Certified Nursing Assistants on proper handling of resident food items and hand hygiene when serving resident meals and the Licensed Nurses on posting proper signage per the specific transmission based precautions.	

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 07/12/2023

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

(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 880	Continued From page 38 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This Requirement is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to ensure proper hand hygiene during meal service for 12 residents (R) from a sample of 35 residents. Staff failed to perform hand hygiene when passing meal trays to R63, R75, R86, R103, R122, R133, R409, R411, R412, R413, 414, and R415. Staff handled residents' food without wearing gloves. The facility also failed to post the correct signage for personal protective equipment (PPE) for two residents of six residents on transmission-based precautions. (R3 and R139). The facility also failed to ensure that the posted precautions were followed for one of six residents on transmission-based precautions (Resident #34). These combined failures have the potential to widely transmit infectious agents and increase the risk of facility-acquired infections. Finding include: 1. Staff failed to perform hand hygiene when passing meal trays.	F 880	This education was completed by 8/4/23. Any employee not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new hire orientation. 4. The Infection Preventionist/ Assistant Director of Nursing will randomly monitor donning and doffing of PPE in conjunction with transmission based precautions, posted signage and resident meal delivery 2 times per week for 4 weeks then weekly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	8/4/23

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 07/12/2023

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

(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 880	Continued From page 39	F 880		

Review of the facility's undated policy titled "Serving a Meal" reads in part "Perform hand hygiene prior to passing the first tray ...Place the tray on the dining table or over bed table if the resident eats in their room ...Avoid handling unwrapped food with bare hands ...Perform additional hand hygiene after touching items in the resident's room or if hands become visibly soiled ..."

Observation of breakfast on 07/11/23 at 07:39 AM on the fifth floor revealed the Assistant Director of Nursing (ADON) announcing the arrival of the breakfast cart on the unit. Certified Nursing Assistant (CNA)5 pulled out a tray and went R411's room and arranged the meal tray on the overbed table for the resident. CNA5 left the room and went to the meal cart without performing hand hygiene and pulled out another tray. CNA5 took this tray to R409's room and placed the tray on the overbed table. The CNA5 moved the overbed table so the resident could reach her food. CNA5 left the room without performing hand hygiene and went to the coffee cart to obtain coffee and condiments for R133. CNA 5 left the resident's room and made a phone call to the kitchen for a resident's request. Without performing hand hygiene, the CNA5 returned to the meal cart and pulled a tray for R415 and set up the tray on the resident's overbed table. CNA5 left the resident's room again without performing hand hygiene and removed a tray from the meal cart, added a cup of coffee, condiments, and entered R413's room. CNA5 arranged the resident's meal tray and bed covers. CNA 6 was observed in R414's room setting up the meal tray and came directly out of the room without performing hand hygiene. CNA5 requested CNA6's assistance in repositioning R412 in bed.

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 07/12/2023

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

(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 880	Continued From page 40	F 880		

Neither CNAs performed hand hygiene before or after assisting R412 in bed. Both CNAs walked past sanitizer wall units and bottles of hand sanitizer on the medication and treatment carts; and the coffee cart without utilizing any of the units. Both CNAs returned to the meal cart. CNA5 pulled a tray for R86, took it to her room, and set up the tray on the resident's overbed table. CNA5 left R86's room without performing hand hygiene. CNA6, without performing hand hygiene, removed a meal try for R63, took it to her room, and set it up to feed the resident. CNA6 was then observed tearing the breakfast bagel into small pieces with his bare hands.

During an interview on 07/11/23 at 08:03 AM, CNA5 stated that she has been taught to perform hand hygiene after serving every two trays. When questioned further, CNA5 then changed her answer to performing hand hygiene after every tray. CNA admitted that she had not performed any hand hygiene during the meal service. Interview on 07/11/23 at 08:08 AM, CNA 6 stated that he sanitized his hands at the start of meal service and performed hand hygiene in the residents' rooms that he served trays.

During an interview on 07/11/23 at 09:51 AM, the Assistant Director of Nursing (ADON)/Infection Control Preventionist stated that the issue of hand hygiene has been addressed in several meetings. The ADON stated that it is an expectation that staff will perform hand hygiene when passing each tray each.

During an interview on 07/12/23 at 10:15 AM, with the ADON and the Infection Control Preventionist 7(in orientation), the ADON stated that she had observed CN6 and CNA5 not performing hand hygiene while passing trays. The ADON stated

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 07/12/2023

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

(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 880	Continued From page 41	F 880		

that she had reminded both employees that they should perform hand hygiene after passing each tray. The ADON stated that she instructed the two CNAs to pass this onto the other employees. The ADON also stated that even after reminding CNA 6 to perform hand hygiene, he failed to do so.

2. Staff failed to wear gloves before directly touching resident's food.

Review of the facility's undated policy titled "Serving a Meal" reads in part "Perform hand hygiene prior to passing the first tray ...Place the tray on the dining table or over bed table if the resident eats in their room ...Avoid handling unwrapped food with bare hands ...Perform additional hand hygiene after touching items in the resident's room or if hands become visibly soiled ..."

Observation on 07/11/23 at 8:04 AM, CNA4 was assisting R122 with setting up his food tray on the overbed table. At 8:06 AM, after assisting R122, CNA4 went over to R75's tray and picked up the resident's bagel with her bare hands, tearing the bagel into smaller pieces. At 8:15 AM, CNA4 picked up R103's bagel and tore it into smaller pieces with her bare hands. CNA4 was not observed to wash her hands between assisting any of the residents with their trays or before touching the bagels with her bare hands. At 8:16 AM, CNA4 was observed handling R122's straw with her bare hands. On 07/11/23 at 8:16 AM, when asked if she had washed her hands and/or wore gloves prior to touching the residents' food with her bare hands, CNA4 stated that she had not.

On 07/11/23 at 4:45 PM, the observations were shared with the Director of Nursing (DON) who

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 07/12/2023

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

(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 880	Continued From page 42	F 880		

stated that CNA 4 should have used utensils to cut up the resident's food or should have worn gloves when she touched the food.

3. The facility failed to post the correct signage for isolation precautions.

Review of the facility's policy titled "Transmission Based Precautions' dated 07/25/18 reads in part "Contact isolations precautions - healthcare personnel caring for resident wears gloves and gowns. Droplet Precautions - healthcare personnel must wear a mask for close contact with infectious resident ..."

Observation during the initial tour on 07/11/23 at 11:41 revealed R3's signage on the door indicated that droplet and contact precautions were to be observed, directing that staff must wear gowns, gloves, mask, face shield/goggles.

Observation on 07/11/23 at 10:30AM revealed CNA 6 and CNA8 in the R3's room wearing face mask, gown, and gloves. They were not wearing face shield/goggles as posted on R3's door.

Review of R3's "Physicians Orders" for the month of July 2023 located under "Orders" tab revealed orders for contact isolation for multidrug resistant organisms.

During an interview on 07/11/23 at 11:00 AM, CNA8 revealed that she had not looked at the sign posted on the door. CNA8 stated that she thought she needed just the mask, gown, and gloves.

During the facility tour on 07/11/23 at 11:41AM, R139's door was observed to have signage posted for contact isolation precautions, directing

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 07/12/2023

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

(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 880	Continued From page 43	F 880		

staff to perform hand hygiene before entering and when leaving the room. The signage also directed that staff must put on gloves and gown before entering the room and discard before exiting the room, as well as stating, "Do not wear the same gown and gloves for the care of more than one resident."

Observation on 07/10/23 at 12:19 PM revealed a CNA8 entering R139's room without donning any PPE. The CNA wore an N95 face mask on her arm. CNA8 arranged R139's bed sheets, removed a pair of discarded gloves from the dresser and tossed them in the trash can. CNA8 exited R139's room and donned a pair of gloves, returned to the resident's room without donning any PPE, and removed the trash from R139's room. CNA8 emptied the trash can to the resident's room and removed her gloves. CNA8 failed to perform hand hygiene before going to the next resident's room.

Review of R139's "Physicians Orders" for the month of July 2023 located in R139's EMR under the "Orders" revealed orders for contact isolation precautions: Staff to wear gown, gloves, and mask when in resident's room.

During an interview on 07/10/23 at 1:30 PM, CNA 8 stated she was only pulling the trash from the resident's room and did not think she needed to wear the PPE when emptying the trash. Reminded CNA8 that she was observed at the R139's bedside adjusting his linen. CNA8 then acknowledged that she failed to perform hand hygiene before going to the next resident.

Interview and tour on 07/11/23 at 12:30 PM with the Unit Manager Registered Nurse (RN)5 revealed that R3's isolation signage was

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 07/12/2023

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

(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 880	Continued From page 44	F 880		

incorrect. According to RN5, R3 should be on contact isolation precautions, not droplet precautions adding that staff should wear gowns and gloves. RN5 then stated that R139 was also on contact isolation precautions, adding that CNA8 should have worn PPE when entering R139's room.

Interview on 07/12/23 at 10:30 AM with the Assistant Director of Nursing (ADON) and Infection Control Preventionist (ICP)7 revealed currently all the residents on the fifth floor were on contact isolation precautions. The ADON stated all the staff on the fifth floor had received training regarding the types of isolation precautions. The ADON stated the Unit Manager was responsible for ensuring the correct signage was posted on the resident's door and ensuring the staff was adhering to the directions. The ADON then stated that she did not realize the incorrect signage was posted for R3 and that staff were not following isolation precautions for R139.
4. Facility staff failed to ensure infection control practices were followed while assisting a resident who was on contact isolation.

On 7/11/23 at 8:10 AM a hospitality aide (Other Staff, OS #1) donned a gown and gloves and entered room 405. A sign was posted on the door instructing staff and visitors of contact isolation and proper personal protective equipment needed. The sign also instructed to discard gown and gloves before exiting the room.

The Resident in room 405, identified as Resident #34, was on contact isolation due to CRE (Carbapenem-resistant enterobacteriaceae), a bacterial infection.

Approximately 5 minutes later, OS #1 came out

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 07/12/2023

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

(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 880	Continued From page 45 of room 405 wearing the same gown, went across the hallway to room 404 to help another resident with a breakfast tray, then removed the gown, and put it into the trash can. On 7/11/23 at 8:27 AM, OS #1 was interviewed regarding wearing a gown from one room to another. OS #1 said that the gown is supposed to be removed prior to exiting the room, but had gotten in a hurry and did not take the gown off. On 7/11/23 at 4:29 PM, the above finding was presented to the administrator and director of nursing (DON). The DON verbalized that the facility has been doing a lot of education with infection control issues and OS #1 should have disposed of the gown before leaving the room. No other information was presented prior to exit conference on 7/12/23.	F 880		