FOIA Data Base - The Law Office of Jeffrey Downey

Serving clients in Washington D.C., Virginia and Maryland

If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation.

Phone: 703-564-7318; email: jdowney@jeffdowney.com
www.jeffdowney.com

Regency Care of Arlington
1785 South Hayes Street
Arlington, VA 22202

Facility Characteristics:

- Skills Nursing Facility with 240 beds
- Operating Manager Employee is Dennis Denny
- Website at www.regencycarearlington.com
- The For-profit corporation is owned by Regency Care of Arlington, LLC
- As of 2018 Regency Care of Arlington was evaluated as a two-star facility (much below average) on Medicare.gov

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:
Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The Virginia Department of Health inspects nursing homes including Regency Care of Arlington. Periodically they do inspections as complaint surveys which should be public record. State law requires that all nursing facilities obtain a license to operate in Virginia. There are more than 279 nursing facilities containing 31,927 beds located throughout Virginia. All but fifteen nursing facilities are certified for federal reimbursement under Medicare and Medicaid. In Virginia, nursing facilities and inspected every two years under the state licensure and on an average of 12 months under Medicare/Medicaid certification. When the Virginia Office of Licensure and

Certification (OLC) conducts inspections and investigations in response to complaints received from the public, the identity of the complainant and the identity of any patient who is the subject of the complaint, or identified therein, shall be treated as confidential and shall not be open to inspection by members of the public. Nothing contained herein shall prevent the OLC or its employees from making reports under §63.2-1603 et. seq. of the Code of Virginia. (Ref. §32.1-127.1:03 of the Code of Virginia) You can register a complaint by mailing to Virginia Department of Health, Office of Licensure and Certification, Virginia Department of Health, 9960 Maryland Drive, Suite 401, Henrico, VA 23233-1463 or via email at OLC-Complaints@vdh.virginia.gov.

Having already researched Regency Care of Arlington, LLC and obtained FOIA responses, I am posting these statements of deficiencies here, in a searchable format. Keep in mind that these surveys have been altered during the conversion process and you should update your search results.

I am interested in any additional information you may have on this facility. Please call me with any question about this or any other facility you may be interested in searching or prosecuting civilly for patient neglect or abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495114	A. BUILDING _____ B. WING _____	**05/17/2017**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility staff failed to conduct a complete and thorough investigation for one of 5 residents in the survey sample, Resident # 5. Resident # 5 had a significant change in condition on [DATE], the resident was sent to the hospital and later expired. According to a facility reported incident dated [DATE], Resident # 5 had allegedly purchased medication that was ordered online and the facility was in the process of attempting to determine what the medication was. The facility staff failed to conduct a complete and thorough investigation regarding this incident. Findings include: Resident # 5 was admitted to the facility originally on [DATE], with the most current readmission on [DATE]. [DIAGNOSES REDACTED]. Resident # 5's most current MDS (Minimum Data Set) dated [DATE] assessed the resident as having a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as requiring extensive assistance from at least two staff members for most all ADL's (activities of daily living). A complaint investigation was conducted on [DATE] through [DATE]. An allegation within the complaint alleged that the facility failed to identify the medication ordered online by the resident. On [DATE] at approximately 1:30 p.m., the administrator and DON (director of nursing) were asked for the investigation for Resident # 5. At approximately 2:25 p.m., the DON presented a folder. The folder contained approximately 4 separate copies of the original FRI (facility reported incident) sent to the state agency, along with a follow up. The follow up was a brief, vague summary and did not include any details regarding the incident surrounding Resident # 5's change of condition or any information about medication being ordered online by the resident. Resident # 5's nursing notes were reviewed. A nursing note dated [DATE] and timed 2:30 p.m. documented (in summary) that at 2:30 p.m. ([DATE]) the resident propelled himself to his room, and requested for CNAs (certified nursing assistants) to put him to bed, he was not feeling well. The CNA called the nurse to the room, the resident was assessed by the nurse, while the resident was in bed. The nursing note documented that the resident was alert and oriented X 3 and able to make needs known at that time. Vital signs were taken and documented (within normal limits). The nurse asked the resident why he was so sleepy and the resident stated that he had taken some medication called tavist, which he had ordered online. The resident did not tell the nurse the amount of medication taken. The nurse and the CNA then searched the room, found 3 round yellow medication (sic) with label (Clamist) in resident drawer with an envelope addressed to the resident at facility. The nursing note then documented that the physician was notified and ordered for close monitoring of resident and morning labs. According to the nursing note at 3:15 p.m., the resident was in bed with noted grunting incoherent and lethargic. Oxygen was initiated, 911 was called and the resident was sent to the hospital via 911 at 3:50 p.m. On [DATE] at 3:15 p.m., the facility's MD (medical director), DON and administrator were interviewed regarding the above information. The MD stated that a couple of days before ([DATE]) the resident had a fall out of his wheelchair and was seen by the MD. According to the MD the resident did not appear in distress after the fall and the resident verbalized that he was fine. Staff got the resident up off the floor and back into the wheelchair without any issues or concerns. The MD stated that on [DATE] the resident's mentation had decreased and that the resident had mentioned taking an over the counter [MEDICATION NAME] and maybe he had taken 2 or 3. The MD stated we sent him out, we were searching his belongings to attempt to find out how many he had taken. The MD stated that after the resident was sent out, the staff searched his scooter and in the pouch/pocket there was a bottle of [MEDICATION NAME] of cannabis plant and that it was a 30 ml (milliliter) bottle and that approximately 10 ml was missing from the bottle, leaving a 20 ml in the bottle. The DON, administrator and MD were all made aware that all of the above information should have been part of their investigation. The DON was asked for a policy on reporting and investigation at this time. The DON stated that, we (the facility) did a time line in the nursing notes. The DON was made aware that there were no statements from the nurse and or CNAs that were caring for Resident # 5 and that critical details surrounding this incident were not provided in their investigation and/or follow up. The facility staff provided a policy titled, Investigative Analysis of Unusual Occurrences of Incidents dated [DATE], documented, .The facility is committed to a comprehensive investigation of all unusual occurrences or incidents .The form is to be completed within 5 calendar days of notification of unusual occurrence .does not replace your requirement to notify all required regulatory or enforcement entities .The form is to be completed entirely . The policy included fill in the blank areas with specific details and a description page to document subjectively. A policy titled, Abuse, Neglect and Exploitation documented, .Neglect means failure of the facility, the employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .interview the involved resident, if possible, and document all responses .if cognitively impaired, interview the resident several times to compare responses .interview the resident's family .or other individual's involved in the resident's life .interview witnesses separately .include roommates, resident's in adjoining rooms, staff members in the area, and visitors in the area. Obtain witness statements .All statements should be signed and dated by the person making the statement .document the entire investigation chronologically .Anyone in the facility can report notify DON and administrator (document), initiate investigation immediately, Notify the attending physician, resident's family .obtain witness statements . No further information and or documentation was provided to the exit conference on [DATE] at 9:00 a.m., to evidence that the facility conducted a complete, thorough and accurate investigation for Resident # 5.
F 0226 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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

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F 0226 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility staff failed to implement written policies and procedures for investigating abuse, neglect and/or exploitation for one of 5 residents in the survey sample, Resident # 5. The facility staff failed to follow written policies and procedures for the prevention of abuse, neglect and/or exploitation of Resident # 5, by not thoroughly investigating an unusual occurrence that had a potential for neglect. Findings include: Resident # 5 had a change in condition on [DATE] and was sent to the hospital, where the resident later expired. According to a facility reported incident dated [DATE], Resident # 5 had allegedly purchased medication that was ordered online and that the facility was in the process of ascertaining what the medication was. The facility staff failed to conduct a complete and thorough investigation regarding this incident. Findings include: Resident # 5 was admitted to the facility originally on [DATE], with the most current readmission on [DATE]. [DIAGNOSES REDACTED]. Resident # 5's most current MDS (Minimum Data Set) dated [DATE] assessed the resident as having a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as requiring extensive assistance from at least two staff members for most all ADL's (activities of daily living). A complaint investigation was conducted on [DATE] through [DATE]. An allegation within the complaint alleged that the facility failed to identify the medication ordered online by the resident. On [DATE] at approximately 1:30 p.m., the administrator and DON (director of nursing) were asked for the investigation for Resident # 5. At approximately 2:25 p.m., the DON presented a folder. The folder contained approximately 4 separate copies of the original FRI (facility reported incident) sent to the state agency, along with a follow up. The follow up was a brief, vague summary and did not include any details regarding the incident surrounding Resident # 5's change of condition or any information about medication being ordered online by the resident. Resident # 5's nursing notes were reviewed. A nursing note dated [DATE] and timed 2:30 p.m. documented (in summary) that at 2:30 p.m. ([DATE]) the resident propelled himself to his room, and requested for CNAs (certified nursing assistants) to put him to bed, he was not feeling well. The CNA called the nurse to the room, the resident was assessed by the nurse, while the resident was in bed. 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No further information and or documentation was provided prior to the exit conference on [DATE] at 9:00 a.m., to evidence that the facility staff followed written policies and/or procedure for the prevention of abuse, neglect and/or exploitation for Resident # 5.