

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/22/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2020
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF ARLINGTON, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 COVID-19 Focused Survey was conducted offsite from 4/7/20 through 4/9/20 and on 6/15/20. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000			
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted 4/7/20 through 4/9/20 and on 6/15/20. The facility was in substantial compliance with 42 CFR Part 483.80 infection control regulations, and had implemented the CMS and Centers for Disease Control (CDC) recommended practices to prepare for COVID-19. On 06/15/2020, the census in this 240 bed certified facility was 119. There were 14 COVID-19 positive residents in the facility. All residents had been tested and 105 were negative. All staff had been tested and 8 were positive. No other staff or residents had been tested at the time of the survey.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.