PRINTED: 08/18/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDIC SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495011 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD MANORCARE HEALTH SERVICES-ALEXANDRIA **ALEXANDRIA, VA 22308** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 000 INITIAL COMMENTS F 000 An unannounced Medicare/Medicaid standard survey was conducted 8/9/16 through 8/11/16. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The statements made on The census in this 96 certified bed facility was 79 this plan of correction are at the time of the survey. The survey sample consisted of 14 current resident reviews not an admission to and (Residents #1 through #13 and #20) and 6 closed do not constitute an record reviews (Residents #14 through #19). F 225 | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) F 225 agreement with the INVESTIGATE/REPORT SS=E alleged deficiencies ALLEGATIONS/INDIVIDUALS herein. To remain in

including injuries of unknown source and misappropriation of resident property are reported

The facility must not employ individuals who have

mistreating residents by a court of law; or have had a finding entered into the State nurse aide

registry concerning abuse, neglect, mistreatment

of residents or misappropriation of their property;

and report any knowledge it has of actions by a court of law against an employee, which would

indicate unfitness for service as a nurse aide or

or licensing authorities.

other facility staff to the State nurse aide registry

The facility must ensure that all alleged violations

involving mistreatment, neglect, or abuse,

been found guilty of abusing, neglecting, or

immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the

State survey and certification agency). LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

compliance with all

regulations, the facility

actions set forth in the

following plan of

following plan of

correction. The

has taken or will take the

correction constitutes the

facility's allegation of

have been or will be

compliance such that all

alleged deficiencies cited

federal and state

(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.

ADMINISTRATOR

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495011	B. WING_	<u> </u>	08	/11/2016
	PROVIDER OR SUPPLIER	ICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	violations are thoroup revent further pote investigation is in p. The results of all into the administrator representative and with State law (inclicertification agency incident, and if the	ave evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported	F 22	corrected by the da	ite or	
	by: Based on staff into and clinical record to report three alleg agency for three of #2, and #19. 1. The facility staff reporting guidelines submit an initial an agency after an alleg 12. 2. The facility staff reporting guidelines submit an initial an agency in the requiallegation of abuse 3. The facility staff reporting guidelines	erview, facility document review review, the facility staff failed gations of abuse to the state 20 Residents, Residents #12, failed to implement the s (required by state law) to d follow-up report to the state egation of abuse by Resident # failed to implement the s (required by state law) to d final report to the state red time frame after a reported for Resident # 2. failed to implement the s (required by state law) to d final report to the state red time frame after a reported for Resident # 2.		F225 It is the practice of the fato ensure that all alleged violations involving mistreatment, neglect, or including injuries of unknown source and misappropriate resident property are repointed in the administrator and to othe officials in accordance we State law through establish procedures (including to	abuse, nown tion of orted r ith	

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 225	agencies, the Virgi the Department of	nia Department of Health and Health Professionals in the e after a reported allegation of	F 225	State survey and certification agency).	on	æ
	reporting guideline submit an initial an agency after an all 12. Resident # 12 was 5/12/15 and readm diagnoses that inc neuropathy, diabel and angina. Resid (minimum data sei Assessment, with date) of 5/22/16 counderstood by others. Resident (Brief Interview for 12 out of 15, indicate cognitively intact. During the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented but agency and the survey reported incidents were presented by the survey reported by the survey reported by the survey reported incidents were presented by the survey reported by the survey report	failed to implement the s (required by state law) to ad follow-up report to the state egation of abuse by Resident # admitted to the facility on hitted on 3/16/16 with luded: osteoarthritis, peripheral les, coronary artery disease lent # 12's most recent MDS to assessment, an Annual an ARD (assessment reference oded Resident # 12 as lers and as able to understand # 12 was coded on the BIMS of Mental Status) with a score of lating that the Resident is at instead "Concern Forms" A "Concern Form" for Resident		Corrective Action Residents #2 and #12 have been reassessed for any negative impact from the alleged abuse and are found be in stable condition and verbalized living in the fact without fear. Resident #19 longer resides in the facility	d to ility no	
	# 12 was reviewed Resident # 12 doc Resident # 12 wen her about a medic that the nurse star	I. The "Concern Form" for umented that on 7/25/16 at to (name of nurse) to remind ation. Resident # 12 related ted yelling at her (Resident 12 reported that the nurse was				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	1 001	11/2010	
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F 225	ASM (administrative administrator, ASM report to your office finished the investion During this intervier abuse and the mean reporting to the state this time a request or facility) that the following state presented by ASM approximately 6:00 Review of The Virgo Office of Licensure "Reporting Abuse, Resident Personne Incidents (FRI)" do Rule. B. When incocur, a federally of self-report those of written report immediate officials requiperstate of the view of t	on 8/10/16 at 4:50 p.m. with the staff member) # 1, the 1 # 1 stated, "I did not send any to (state agency) because I gation and there was no need." with the policy for reporting aning of "immediately" at agency were discussed. At was made for any policy (state facility uses as a guideline. I and facility policies were # 1 on 8/10/16 at 1 p.m. I pinia Department of Health and Certification policy Neglect, Misappropriation of the Property Or Facility Reported cumented under, "General cidences of staff misconduct certified facility is required to cocurrences by filing an initial ediately to the OLC (Office of the best of the Virginia and ServicesNOTE: Facilities orting criteria of other APS/DSS (Adult Protective ent of Social Services) or DHP alth Professional), which may eline."	F 2	II Identification All residents residing in a facility have the potential affected by the alleged depractice. The Administrates designee has completed a review of all concerns sin previous survey by reside family members and four them to be sufficiently investigated and concludinvestigated and concluding the Administrator and of department heads would educated by the Social Woon the policies and process.	to be efficient for or ace the ents or ad ed.		
	following: "Patient I	ty policy documented the Protection Practice Guide" pondReporting. The center		on handling allegations of			

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PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

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F 225 Continued From page 4 must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures (including to the state survey and certification agency). The results of all investigations must to be reported to the administrator or his/her designated representative and to other officials in accordance with state law (including to the state survey and certification agency) with 5 (five) working days of the incident. CMS (Center for Medicare/Medicaid Services) defines "Immediately" to mean as soon as possible, but not ought not to exceed 24 hours after discovery of the incident, in the absence of a shorter time frame requirement." No further documentation was provided prior to exit. 2. The facility staff failed to file an initial and follow-up report with the state agency in the required five days after a reported allegation of abuse for Resident # 2. Resident # 2 was admitted to the facility on 2/14/15 with diagnoses that included but were not limited to: deep venous thrombosis (1), hypertension (2), gastroesophageal reflux disease (3), urinary tract infection (4), diabetes mellitus (5), anxiety (6), depression, muscle					1510 COLLINGWOOD ROAD		1112010
must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures (including to the state survey and certification agency). The results of all investigations must to be reported to the administrator or his/her designated representative and to other officials in accordance with state law (including to the state survey and certification agency) with 5 (five) working days of the incident. CMS (Center for Medicare/Medicaid Services) defines "immediately" to mean as soon as possible, but not ought not to exceed 24 hours after discovery of the incident, in the absence of a shorter time frame requirement." No further documentation was provided prior to exit. 2. The facility staff failed to file an initial and follow-up report with the state agency in the required five days after a reported allegation of abuse for Resident # 2. Resident # 2 was admitted to the facility on 2/14/15 with diagnoses that included but were not limited to: deep venous thrombosis (1), hypertension (2), gastroesophageal reflux disease (3), uninary tract infection (4), diabetes mellitus (5), anxiety (6), depression, muscle	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
weakness, obesity, pain, neurogenic bladder (7), and cerebral vascular accident (8). Resident # 2's most recent comprehensive MDS (minimum data set), a quarterly assessment with	F 225	must ensure that a mistreatment, negli of unknown source resident property, a administrator of the accordance with st procedures (including certification agency investigations must administrator or his and to other official (including to the state agency) with 5 (five CMS (Center for Midefines "immediate possible, but not on after discovery of the shorter time frame. No further docume exit. 2. The facility staff follow-up report with required five days a abuse for Resident # 2 was a 2/14/15 with diagnor limited to: deep very hypertension (2), grading disease (3), urinary mellitus (5), anxiety weakness, obesity, and cerebral vascular Resident # 2's most res	all alleged violations involving ect, or abuse, including injuries et, and misappropriation of are reported immediately to the efacility and other officials in ate law through established ing to the state survey and y)The results of all to be reported to the scher designated representative is in accordance with state law ate survey and certification e) working days of the incident. Idedicare/Medicaid Services ely" to mean as soon as ught not to exceed 24 hours he incident, in the absence of a requirement." Intation was provided prior to effailed to file an initial and the state agency in the after a reported allegation of the eafter a reported allegation of the eafter a reported allegation of the eafter a reported but were not nous thrombosis (1), astroesophageal reflux y tract infection (4), diabetes y (6), depression, muscle pain, neurogenic bladder (7), alar accident (8).	F 22	IV Monitoring The Administrator or design would audit concerns forwarded to the Social Wor other staff members for appropriate investigation a reporting weekly for four weeks and once a month forwarded to Quality Assessment and Assurance Committee for review and	gnee orker and or or d will	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495011	B, WING			1	11/2016
	PROVIDER OR SUPPLIER CARE HEALTH SER	/ICES-ALEXANDRIA		1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308	•	
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F 225	an ARD (assessm coded Resident # interview for ment - 15, 15- being codecisions. Reside extensive assistar one staff member A review of the fact dated 6/16/16 doc 6/15/16. Summar (Resident # 2) rep sexual advances to 14, who works in the during evening homakeup gifts, unsuninvited kissing to 14. The "Investigation documented, "Corinvestigation of this (interdisciplinary to credible, and given accepted that he had be to each other in the fact of the considered the accepted that he had be handled through process, no law end in order to protect resident in the fact (OSM # 14), there termination of (OS in (Name of Facilities).	ent reference date) of 6/22/16, 2 as scoring a 15 on the brief all status (BIMS) of a score of 0 gnitively intact for making daily ent # 2 was coded as requiring ace to being totally dependent of for activities of daily living. Cilities "Investigation Report", umented, "Date of incident: y of Alleged Incident: Patient, orted an allegation of unwanted by OSM (other staff member) # housekeeping and laundry urs. She cited buying of olicited neck massage, other cheeks and lips." Report" dated 6/17/16 inclusion: After thorough is allegation, the IDT eam) finds the resident to be in the fact that (OSM # 14) inad bought makeups for the bough they are not in any way her, has sustained that at (OSM # 14) made unwanted towards (Resident # 2). The resident and any other inforcement agency is notified. The resident and any other illity from such behaviors by fore the IDT recommends the important of the proposed in the services by effective immediately. (OSM d a license of any kind that	F	225	Assurance Committee will determine the need for furth audits and/or action plans. V Date of Compliance 9/16/2016	ier	

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would have warranted notification of such a

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DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICAD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011			, ,	ING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	08/	<u>11/2016</u>	
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F 225	Report" dated 6/16 evidence the initial this incident was p licensure and certiin On 8/10/16 at 4:30 conducted with AS member) # 1, the awhy the allegation not reported to the certification ASM # because the emploisment of the certification ASM # because the employer of the certification ASM # because the emploisment of the certification ASM # because the employer of the certification ASM # because the certification ASM # because the employer of the certification ASM # because the employer of the certification ASM # because the certification AS	the facility's "Investigation 6/16 and 6/17/16 failed to I allegation and the follow up to provided to OLC (office of ification). D. p.m. an interview was 6M (administrative staff administrator. When asked of abuse by Resident # 2 was a office of licensure and # 1 stated, "I didn't send it oyee was not licensed." D. p.m. ASM (administrative staff administrator, and ASM # 2, the were made aware of the were made aware of the atton was provided by the end of the occurs when a blood clot ep inside a part of the body. It large veins in the lower leg and our in other deep veins such as elvis. This information was website: S. gov/ency/article/000156.htm>. Ssure. This information was website: Signov/medlineplus/highbloodpr		225				
	(3) Stomach conte	ents to leak back, or reflux, into					.0	

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

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' ' =	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER CARE HEALTH SER	/ICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CO 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
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F 225	the esophagus an was obtained from https://www.nlm.ni (4) An infection in information was of https://www.nlm.ni 000521.htm. (5) A chronic disearegulate the amount information was of ttps://www.nlm.ni 001214.htm. (6) Fear. This information was of ttps://www.nlm.ni (7) A problem in word to a broad to a bro	d irritate it. This information is the website: ih.gov/medlineplus/gerd.html. the urinary tract. This betained from the website: ih.gov/medlineplus/ency/article/dase in which the body cannot ant of sugar in the blood) This betained from the website: ih.gov/medlineplus/ency/article/dase in which the body cannot ant of sugar in the blood) This betained from the website: ih.gov/medlineplus/ency/article/dase. The person lacks bladder rain, spinal cord, or nerversion was obtained from segov/ency/article/000754.htm. Information was obtained from ih.gov/medlineplus/ency/article/dase. The failed to file an initial and ith the state agencies, the ent of Health and the alth Professionals in the ne after a reported allegation of	F2	225			

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DEPARTMENT OF HEALTH AND HUT Y SERVICES CENTERS FOR MEDICARE & MEDIC SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495011	B. WING _		08	C / 11/2016
MANORCARE HEALTH SERVICES-ALEXANDRIA (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 225 Continued From page 8 Resident # 19 was admitted to the facility on 3/21/16 with diagnoses that included but were limited to: low iron, coronary artery disease (1) hypertension (2), hyponatremia (3), anxiety (4) and depression. Resident # 19's most recent MDS (minimum d set), an admission assessment with an ARD (assessment reference date) of 3/28/16, coded Resident # 19 as scoring a 15 on the brief interview for mental status (BIMS) of a score of -15, 15- being cognitively intact for making daid decisions. Resident # 19 was coded as require extensive assistance of one staff member for activities of daily living. A review of the facility's "Concern Form" dated 4/22/16 documented, "Documentation of Concern: Pt (Patient [Resident #19]) alleged				STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		7172010
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	Resident # 19 was 3/21/16 with diagn	s admitted to the facility on loses that included but were not	F 22	25		
	hypertension (2), hand depression. Resident # 19's m	nyponatremia (3), anxiety (4) ost recent MDS (minimum data		•		
	(assessment refer Resident # 19 as s interview for ment - 15, 15- being cog decisions. Reside extensive assistan	rence date) of 3/28/16, coded scoring a 15 on the brief all status (BIMS) of a score of 0 gnitively intact for making daily ent # 19 was coded as requiring acc of one staff member for				
	4/22/16 document Concern: Pt (Patie inappropriate touc	ed, "Documentation of			62	
¥	documented, "Acti The male staff nar suspended immed investigation. The physician were no allegation; therefo initiated." Under " "The allegation of unsubstantiated. withdrawn her alle received a coachi relations. The phy	Report" dated 4/22/16 ion Taken During Investigation: med in the allegation was diately while conducting the epatient's daughter and tified. Patient withdrew the re, no state report was Conclusion" it documented, inappropriate touching is The patient [Resident #19] had gation as well. The employee ng regarding positive customer ysician issued no new orders.				

DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	CES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	1 00/	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	Further review of the dated 4/22/16 failed allegation and the for provided to OLC (of certification) and DI Professionals). On 8/10/16 at 4:30 conducted with ASM member) # 1, the awhy the allegation of not reported to the Certification and the Professionals ASM because the reside wasn't intentional." On 8/10/16 at 5:50 member) # 1, the addirector of nursing with findings. No further information the survey. References: (1) Common type of information was obth https://www.nlm.nih.rydisease.html. (2) High blood pressionals days and the with the survey.	e facility's "Concern Form" It to evidence the initial collow up to this incident was ffice of licensure and HP (Department of Health p.m. an interview was M (administrative staff dministrator. When asked of abuse by Resident # 19 was Office of Licensure and a Department of Health # 1 stated, "I didn't send it not stated it (the incident) p.m. ASM (administrative staff dministrator, and ASM # 2, the were made aware of the work was provided by the end of the financial from the website: gov/medlineplus/coronaryarte sure. This information was website: gov/medlineplus/highbloodpr	F 2			
	483.13(c) DEVELO ABUSE/NEGLECT,		F 2	26		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC....ರ SERVICES

PRINTED: 08/18/2016 **FORM APPROVED** OMB NO. 0938-0391

495011 R VICES-ALEXANDRIA TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		C <u>11/2016</u>
VICES-ALEXANDRIA TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	,	
CY MUST BE PRECEDED BY FULL	PREFIX	DROVIDEDIS DI ANI OF CORDECTI		
		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
develop and implement written edures that prohibit glect, and abuse of residents tion of resident property. ENT is not met as evidenced terview, facility document review direview, the facility staff failed egations of abuse to the state cility abuse policy for three of 20 ents # 12, # 2, and # 19. If failed to implement the facility in initial and follow-up report to after an allegation of abuse by If failed to implement a policy to a final report to the state uired time frame after a reported the for Resident # 2. If failed to implement a policy to and final report to the state	F 220	F226 It is the practice of the faci to develop and implement written policies and proced that prohibit mistreatment, neglect, and the abuse of	lures	
f Health Professionals in the ne after a reported allegation of				
f failed to implement the facility ninitial and follow-up report to				
	develop and implement written edures that prohibit glect, and abuse of residents tion of resident property. ENT is not met as evidenced terview, facility document review dreview, the facility staff failed egations of abuse to the state cility abuse policy for three of 20 ents # 12, # 2, and # 19. If failed to implement the facility in initial and follow-up report to after an allegation of abuse by wiff failed to implement a policy to and final report to the state uired time frame after a reported se for Resident # 2. Iff failed to implement a policy to and final report to the state ginia Department of Health and if Health Professionals in the me after a reported allegation of a failed to implement the facility in initial and follow-up report to after an allegation of abuse by	develop and implement written edures that prohibit glect, and abuse of residents tion of resident property. ENT is not met as evidenced terview, facility document review d review, the facility staff failed egations of abuse to the state cility abuse policy for three of 20 ents # 12, # 2, and # 19. If failed to implement the facility in initial and follow-up report to after an allegation of abuse by off failed to implement a policy to and final report to the state uired time frame after a reported se for Resident # 2. off failed to implement a policy to and final report to the state ginia Department of Health and off Health Professionals in the me after a reported allegation of ant #19.	develop and implement written edures that prohibit glect, and abuse of residents tion of resident property. ENT is not met as evidenced terview, facility document review dreview, the facility staff failed egations of abuse to the state cility abuse policy for three of 20 ents # 12, # 2, and # 19. If failed to implement the facility in initial and follow-up report to after an allegation of abuse by fiff failed to implement a policy to after an allegation of abuse by fiff failed to implement a policy to and final report to the state cuired time frame after a reported are for Resident # 2. If failed to implement a policy to and final report to the state cuired time frame after a reported are for Resident # 2. If failed to implement a policy to and final report to the state cuired time frame after a reported are for Resident # 2. If failed to implement a policy to and final report to the state cuired time frame after a reported are for Resident # 2. It is the practice of the faci to develop and implement written policies and proceed that prohibit mistreatment, and the abuse of residents and misappropria of resident property.	develop and implement written edures that prohibit glect, and abuse of residents tion of resident property. ENT is not met as evidenced terview, facility document review of review, the facility staff failed egations of abuse to the state cility abuse policy for three of 20 ents # 12, # 2, and # 19. If failed to implement the facility in initial and follow-up report to after an allegation of abuse by If failed to implement a policy to a final report to the state uired time frame after a reported se for Resident # 2. If failed to implement a policy to and final report to the state uired time frame after a reported se for Resident # 2. If failed to implement a policy to and final report to the state uired time frame after a reported se for Resident # 2. If failed to implement the facility in initial and follow-up report to

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Event ID: CZ4K11

Facility ID: VA0177

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DEPARTMENT OF HEALTH AND HU CENTERS FOR MEDICARE & MEDICA, Ó SERVICES

PRINTED: 08/18/2016 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495011	B. WING			I	C 11/2016
	PROVIDER OR SUPPLIER	VICES-ALEXANDRIA		15	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308	1 001	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Resident # 12 was 5/12/15 and readn diagnoses that inconeuropathy, diabe and angina. Residential (minimum data se Assessment, with date) of 5/22/16 counderstood by oth others. Resident (Brief Interview for	age 11 s admitted to the facility on nitted on 3/16/16 with cluded: osteoarthritis, peripheral tes, coronary artery disease dent # 12's most recent MDS assessment, an Annual an ARD (assessment reference oded Resident # 12 as ers and as able to understand # 12 was coded on the BIMS of Mental Status) with a score of atting that the Resident is		226	Corrective Action A follow up visit has been completed by the Social Worker with the residents # and #2 for new or further concerns of mistreatment or abuse. No new concerns we noted. Resident #19 no long resides in the facility.	re	
	reported incidents were presented by were presented. If 12 was reviewed Resident # 12 were her about a medic that the nurse star Resident # 12 rep and insulting. During an interview ASM (administrator, ASI report to your officinished the invest During this interview abuse and the me reporting to the stathis time a reques or facility) that the	process the FRIs (facility) were requested. No FRIs at instead "Concern Forms" A "Concern Form" for Resident d. The "Concern Form" for cumented that on 7/25/16 at to (name of nurse) to remind cation. Resident # 12 related atted yelling at her (Resident). atted yelling at her (Resident). atted that the nurse was rude w on 8/10/16 at 4:50 p.m. with we staff member) # 1, the w # 1 stated, "I did not send any be (state agency) because I digation and there was no need." attention with the policy for reporting caterial agency were discussed. At t was made for any policy (state facility uses as a guideline. ity and state policies were			II Identification All residents residing in the facility have the potential to affected by the alleged deficience.	be	

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Event ID: CZ4K11

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PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495011	B. WING_			/11/2016	
	PROVIDER OR SUPPLIER	/ICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		5/11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 226	presented by ASM approximately 6:00 Review of the facil following: "Patient under "Report/Resmust ensure that a mistreatment, neg of unknown source resident property, administrator of thaccordance with sprocedures (included certification agencinvestigations must administrator or hi and to other official (including to the stagency) with 5 (five CMS (Center for Machines "immediate possible, but not other offices).	# 1 on 8/10/16 at 0 p.m. ity policy documented the Protection Practice Guide" spondReporting. The center all alleged violations involving lect, or abuse, including injuries e, and misappropriation of are reported immediately to the e facility and other officials in tate law through established ling to the state survey and byThe results of all but to be reported to the sher designated representative als in accordance with state law ate survey and certification be) working days of the incident. Medicare/Medicaid Services) also to exceed 24 hours the incident, in the absence of a	F 22	III Systematic Chan The Administrator and Department Heads wou educated by the Social on the policies and pro- that prohibit mistreatmeneglect, and abuse of re and misappropriation or resident property.	other ald be re- Worker cedures ent, esidents		
	Office of Licensure "Reporting Abuse, Resident Personne Incidents (FRI)" do Rule. B. When in occur, a federally consulten report those owritten report immulicensure and Cerstate officials required.	ginia Department of Health e and Certification policy Neglect, Misappropriation of el Property Or Facility Reported ocumented under, "General cidences of staff misconduct certified facility is required to ccurrences by filing an initial ediately to the OLC (Office of tification) and to any other ired by state law. e.g. the Adult is Unit of the Virginia cial ServicesNOTE: Facilities		IV Monitoring The Administrator or d will audit concerns of r weekly for four weeks	esidents		

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

PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			G	(X3) DATE SURVEY COMPLETED	
		495011	B. WING		C 08/11/2016
	PROVIDER OR SUPPLIER	ICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	1 00/1/12010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 226	agencies, such as Services/ Departm (Department of He vary from this guid	orting criteria of other APS/DSS (Adult Protective ent of Social Services) or DHP alth Professional), which may	F 220	monthly for two months. I collected will be forwarde Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for fur audits and/or action plans.	d to
	submit an initial an agency in the requallegation of abuse Resident # 2 was a 2/14/15 with diagn limited to: deep ve hypertension (2), gdisease (3), urinar mellitus (5), anxiet weakness, obesity and cerebral vascul Resident # 2's mos (minimum data sean ARD (assessme coded Resident # interview for mental 15, 15- being cog decisions. Reside extensive assistant one staff member	admitted to the facility on oses that included but were not nous thrombosis (1), pastroesophageal reflux y tract infection (4), diabetes y (6), depression, muscle pain, neurogenic bladder (7),		V Date of Compliance 9/16/2016	

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Event ID: CZ4K11

Facility ID: VA0177

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						E SURVEY PLETED	
		495011	B. WING				C 11/2016
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, Z 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 226	dated 6/16/16 docu 6/15/16. Summary (Resident # 2) repo sexual advances by 14, who works in he during evening hou makeup gifts, unso uninvited kissing to The "Investigation of this (interdisciplinary teacredible, and given accepted that he have resident as gift thou related to each other resident as gift thou related to each other resident's claim that sexual advances to However, given that considered the action be handled through process, no law end In order to protect the resident in the facility (OSM # 14), therefore termination of (OSM in (Name of Facility # 14) does not hold would have warrant board." Further review of the Report" dated 6/16/evidence the initial athis incident was prolicensure and certification.	mented, "Date of incident: of Alleged Incident: Patient, rted an allegation of unwanted of OSM (other staff member) # busekeeping and laundry rs. She cited buying of licited neck massage, her cheeks and lips." Report" dated 6/17/16 clusion: After thorough allegation, the IDT am) finds the resident to be the fact that (OSM # 14) and bought makeups for the light they are not in any way er, has sustained that the (OSM # 14) made unwanted wards (Resident # 2). If the resident, in no way on as abuse, but a concern to the facility's disciplinary forcement agency is notified. The resident and any other the IDT recommends the M # 14's) employment services of effective immediately. (OSM a license of any kind that ed notification of such a license of any kind that ed notification and the follow up to ovided to OLC (office of	F 2	26			

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



PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		495011	B. WING			C 08/11/2016		
	PROVIDER OR SUPPLIER	ICES-ALEXANDRIA		1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	1 001	11/2010	
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 226	member) # 1, the a why the allegation of not reported to the certification ASM # because the emplo On 8/10/16 at 5:50 member) # 1, the adirector of nursing of findings. No further informate the survey. References: (1) A condition that forms in a vein deemainly affects the late thigh, but can occur in the arms and periodic the arms and periodic in the arms and period	M (administrative staff administrator. When asked of abuse by Resident # 2 was office of licensure and 1 stated, "I didn't send it ayee was not licensed." p.m. ASM (administrative staff administrator, and ASM # 2, the were made aware of the were made aware of the arge veins in the lower leg and r in other deep veins such as livis. This information was vebsite: s.gov/ency/article/000156.htm sure. This information was vebsite: ih.gov/medlineplus/highbloodp atts to leak back, or reflux, into a irritate it. This information the website: n.gov/medlineplus/gerd.html.	F	226				
	information was ob	tained from the website: ih.gov/medlineplus/ency/article						

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

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

(X2) MULTIPLE CONSTRUCTION

PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495011	B. WING		_	ł	C
	PROVIDER OR SUPPLIER CARE HEALTH SERVI			ST 15	REET ADDRESS, CITY, STATE, ZIP CODE 10 COLLINGWOOD ROAD LEXANDRIA, VA 22308	1 06/	<u>11/2016</u>
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	regulate the amoun information was ob https://www.nlm.n/001214.htm . (6) Fear. This infor website: https://www.nlm.nml/#summary . (7) A problem in who control due to a bracondition. This information the website: https://medlineplu . (8) A stroke. This in the website: https://www.nlm.nih000726.htm . 3. The facility staff submit an initial and agencies, the Virgin the Department of	ge 16 se in which the body cannot at of sugar in the blood) This tained from the website: ih.gov/medlineplus/ency/article mation was obtained from the ih.gov/medlineplus/anxiety.ht sich a person lacks bladder ain, spinal cord, or nerve armation was obtained from s.gov/ency/article/000754.htm Information was obtained from a.gov/medlineplus/ency/article/failed to implement a policy to definal report to the state and Department of Health and Health Professionals in the eafter a reported allegation of	F	2226	DEFICIENCY)		
¥	3/21/16 with diagnoral limited to: low iron, hypertension (2), hyand depression.	# 19. admitted to the facility on oses that included but were not coronary artery disease (1), apponatremia (3), anxiety (4) ast recent MDS (minimum data					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC. D SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495011	B. WING	3. WING		C 08/11/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 1510 COLLINGWOOD ROA ALEXANDRIA, VA 2230	AD	1 00/	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECTIVE CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE
F 226	set), an admission (assessment referesident # 19 as interview for menter - 15, 15- being condecisions. Reside extensive assistant activities of daily I A review of the fact 4/22/16 documented. The management of	n assessment with an ARD rence date) of 3/28/16, coded scoring a 15 on the brief all status (BIMS) of a score of 0 gnitively intact for making daily ent # 19 was coded as requiring nce of one staff member for iving. cility's "Concern Form" dated ted, "Documentation of ent [Resident #19]) alleged ching by staff CNA (certified during transfer on 4/17/16." In Report" dated 4/22/16 tion Taken During Investigation: med in the allegation was diately while conducting the expatient's daughter and officed. Patient withdrew the pre, no state report was "Conclusion" it documented, inappropriate touching is The patient [Resident #19] had egation as well. The employee ng regarding positive customer ysician issued no new orders. It was fully satisfied with conduct	F	226			

DEPARTMENT OF HEALTH AND HUMON SERVICES CENTERS FOR MEDICARE & MEDICARE & SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		49 5011	B. WING_		1	C 11/2016
	PROVIDER OR SUPPLIER	CES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	1 007	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE	(X5) COMPLETION DATE
F 226	conducted with ASI member) # 1, the a why the allegation of not reported to the Certification and the Professionals ASM because the reside wasn't intentional." On 8/10/16 at 5:50 member) # 1, the a director of nursing of findings. No further information the survey. References: (1) Common type of information was observed information was observed information was observed information was observed in the survey. (2) High blood pressobtained from the vestigned from the vestigned in the vestigned	M (administrative staff dministrator. When asked of abuse by Resident # 19 was Office of Licensure and e Department of Health # 1 stated, "I didn't send it nt stated it (the incident) p.m. ASM (administrative staff dministrator, and ASM # 2, the were made aware of the vere made aware of the stained from the website: ih.gov/medlineplus/coronaryart sure. This information was vebsite: ih.gov/medlineplus/highbloodp It) level. This information was vebsite: s.gov/ency/article/000394.htm	F 22			
F 252	website: website: https://www.nlm.n ml#summary>.	mation was obtained from the ih.gov/medlineplus/anxiety.ht	F 25	52		

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



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	COM	E SURVEY IPLETED	
		495011	B. WING			1	C 11/2016
	AME OF PROVIDER OR SUPPLIER IANORCARE HEALTH SERVICES-ALEXANDRIA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 252 Continued From page 19 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belonging to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and clinical record review it was determined that the facility staff failed to maintain a resident's room a clean manner for one of 20 residents in the survey sample, Residents # 6. A strong urine odor was noted in Resident # 6's room. The findings include: Resident # 6 was admitted to the facility on			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD ILEXANDRIA, VA 22308	1 00/	111/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	SAFE/CLEAN/CO ENVIRONMENT The facility must p comfortable and h the resident to use to the extent possion This REQUIREME by: Based on observa clinical record revifacility staff failed a clean manner for	rovide a safe, clean, omelike environment, allowing his or her personal belongings lible. ENT is not met as evidenced ations, staff interview and ew it was determined that the to maintain a resident's room in rone of 20 residents in the	F2	252	F252 This facility is in the practic providing a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	ce of	
	The findings include:				I Corrective Action The room of resident #6 was immediately cleaned follow awareness of the issue by the staff. The resident's bedding were changed. The floor was buffed and waxed. No odor further noted.	ring le gs ls	

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF IND PLAN OF CORRECTION IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495011	B. WING		08	C 5/ 11/2016	
	PROVIDER OR SUPPLIER	ICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CO 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		71172010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(X5) COMPLETION DATE		
F 252	dependent of one daily living. Reside "Occasionally inco "Frequently inconti Observations of Re 1:40 p.m., 3:10 p.r odors of urine. Fu # 6's room reveale emanating from Re Observations of the	sive assistance to being totally staff member for activities of ent # 6 was coded as being ntinent" of bowel and nent" of bladder. esident # 6's room on 8/9/16 at n. and 3:35 p.m. revealed rther observations of Resident d concentrated odors of urine esident # 6's bed. e bed linens did not reveal stained. Resident # 6 was	F 2	All residents residing ir facility who are depend incontinent care have th potential to be affected alleged deficient practic	n the lent for ne by this		
	Observations of Resident # 6's room were conducted with another state surveyor on 8/9/16 at 3:45 p.m. The other state surveyor confirmed odors of urine in Resident # 6's room. Further observations of Resident # 6's with the other state surveyor confirmed concentrated odors of urine emanating from Resident # 6's bed. On 8/9/16 at 3:50 p.m. an observation and interview was conducted with LPN (licensed practical nurse) # 2 in Resident # 6's room. When asked if Resident # 6's room smelled clean, LPN # 2 stated, "It doesn't smell good." When asked if the room and bed had an odor of urine, LPN # 2 stated, "I don't know how to answer your question." On 8/9/16 at 3:55 p.m. an observation and interview was conducted with CNA (certified nursing assistant) # 7 in Resident # 6's room. When asked if Resident # 6's room smelled clean, CNA # 7 stated, "The room doesn't smell clean." After smelling the Resident # 6's bed,			Systematic Chan The Administrator or D will educate the Nursin Assistants and Houseke Staff on keeping resider rooms and other parts of	Designee geping nt's of the		

DEPARTMENT OF HEALTH AND HUT IN SERVICES CENTERS FOR MEDICARE & MEDIC ID SERVICES

	PRINTED: 08/18/2010
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7	OMB NO. 0938-039

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY
		495011	B. WING		I .	C (44/2046
NAME OF E	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO		/11/2016
		/ICES-ALEXANDRIA		1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 252	Resident # 6, CNA 6) on 7 to 3 (7:00 a changed the bed a changed t	ed if she had taken care of a # 7 stated, "I had (Resident # a.m. to 3:00 p.m.) shift. I at 7:30 a.m." p.m. an observation and ducted with ASM (administrative the director of nursing, in m. When asked if Resident # smelled clean, ASM # 2 stated, bod." p.m. ASM (administrative staff administrator, and ASM # 2, the were made aware of the state of the difficult to breath that the ess of breath. This information	F 25	The Administrator of dwill make daily enviror rounds 5 times a week, including resident room ensure cleanliness and free environment for twand weekly for four we Data collected will be forwarded to Quality Assessment and Assura Committee for review a action, as appropriate. Quality Assessment and Assurance Committee we determine the need for audits and/or action plant.	nmental ns to an odor wo weeks eks ance and The d will further	
	of the spine. This the website: https://medlineple">https://medlineple https://medlineple 					

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

PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES TAG	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	ECONSTRUCTION	COMPLETED		
MANORCARE HEALTH SERVICES-ALEXANDRIA CALID CHARLES CHARLES			495011	B. WING		l	016
F 252 Continued From page 22 that affect the brain. This information was obtained from the website: http://www.nlm.nih.gov/medlineplus/dementia.html (5) An enlarged prostate. This information was obtained from the website: http://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html (6) A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: http://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html (7) A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html F 274 SS=D A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the revision.			ICES-ALEXANDRIA	,	1510 COLLINGWOOD ROAD		
that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.h.tml (5) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html (6) A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html F 274 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COM	
care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was	F 274	that affect the brain obtained from the vehttps://www.nlm.rtml>. (5) An enlarged probtained from the vehttps://www.nlm.rostatebph.html>. (6) A condition in vehttps://www.nlm.rivinformation was obhttps://www.nlm.nililure.html. 483.20(b)(2)(ii) COAFTER SIGNIFICAA facility must concassessment of a refacility determines, that there has been resident's physical purpose of this second purpose of this second purpose of this second purpose of this second purpose of the resident's status the itself without furthed implementing standinterventions, that one area of the resident's interdiscipling care plan, or both. This REQUIREME by: Based on staff into the resident of the resident's plan, or both.	n. This information was website: hih.gov/medlineplus/dementia.h ostate. This information was website: hih.gov/medlineplus/enlargedproversite which not enough oxygen ungs into your blood. This stained from the website: h.gov/medlineplus/respiratoryfa MPREHENSIVE ASSESS ANT CHANGE duct a comprehensive esident within 14 days after the or should have determined, in a significant change in the or mental condition. (For estion, a significant change cline or improvement in the at will not normally resolve intervention by staff or by dard disease-related clinical has an impact on more than esident's health status, and dinary review or revision of the or the o		F274 It is the practice of the facilit to conduct a comprehensive assessment of a resident wit 14 days. After the facility determines, or should have determined, that there has be a significant change in a resident's physical or mental	hin	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CZ4K11

Facility ID: VA0177

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DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	riple construction NG	CON	(X3) DATE SURVEY COMPLETED		
		495011	B. WING		- 1	/11/2016	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA				STREET ADDRESS, CITY, STATE, ZIP C 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		1112010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 274	Continued From page	age 23	F 2	74 I			
	a significant chang	e facility staff failed to complete ge MDS assessment for 1 of 20		Corrective Act	ion		
	For Resident #5, the assessment should change MDS asset			The quarterly MDS As of 4-29-16 of Resident been modified to reflesignificant change (8/2)	t #5 has ct a		
	diagnoses of but n cancer, psychosis,	idmitted on 6/16/15 with the ot limited to dementia, prostate, obstructive uropathy, sion, high blood pressure,			,		
	quarterly assessm Reference Date) of coded as severely make daily life dece possible 15 on the Mental Status) exa requiring total care extensive assistant assistance for tran ambulation; and w	AIDS (Minimum Data Set) was a ent with an ARD (Assessment of 7/30/16. The resident was cognitively impaired in ability to disions, scoring a 4 out of a BIMS (Brief Interview for am. The resident was coded as a for bathing and eating; ce for hygiene; limited disfers; supervision for as coded as incontinent of an a catheter for bladder.		II Identification All the residents residing facility have the potent affected by this alleged deficient practice.	ng in the		
	change MDS, and MDS revealed mul status. Upon furth these changes had 2016 quarterly MD the April MDS asse	nuary 28, 2016 significant the July 30 2016 quarterly Itiple changes in the resident's er review, it was revealed that d occurred as of the April 29, S assessment, and therefore essment should have been gnificant change MDS.					

DEPARTMENT OF HEALTH AND HUN Y SERVICES CENTERS FOR MEDICARE & MEDICAGO SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l`'	G	COMPLETED		
		495011	B. WING		C 08/11/201	16
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA				STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	00/11/201	<u>0</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	
F 274	The changes identi	fied are as follows:	F 274	4		
	April 29, 2016 was decline. Behavior; On J marked; On April 2 This was a decline. Bed mobility; O (required extensive 2016 was a 2/3 (retained extensive 2016 was a 2/2 (retained extensive 2	In January 30, 2016 3/2 assistance); On April 29, quired limited assistance.) yement. anuary 30, 2016 was a 3/2 assistance); On April 29, quired limited assistance.) yement. On January 30, 2016 was a sive assistance); On April 29, quired limited assistance.) yement. or; On January 30, 2016 was a sive assistance); On April 29, quired limited assistance.) quired limited assistance.)		Systematic Changes The Administrator or Designwill re-educate the MDS Coordinator and other interdisciplinary team members on determining a significant change assessment, to include significant resident improvement.	pers	
67	Locomotion on was a 3/2 (required April 29, 2016 was assistance.) This was a 3/2 (required April 29, 2016 was assistance.) This was assistance.) This was assistance.	unit; On January 30, 2016 Il extensive assistance); On a 2/2 (required limited was an improvement. i unit; On January 30, 2016 Il extensive assistance); On a 2/2 (required limited was an improvement. s; On January 30, 2016 was an sore; On April 29, 2016, there pressure sores. This was an		IV Monitoring The Administrator or Design will complete a weekly audi completed MDS assessment for four weeks and monthly two months for compliance this requirement. Data	t or s for	

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

PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495011	B. WING			C 11/2016
	PROVIDER OR SUPPLIER	ICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	, 00/	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
F 274	Nurse #1, the MDS significant change there was no negate there was no negate A review of the faci RAI manual (Resid Version 3.0, Octobe 2-22 to 2-24 documents in Deciding in Not:Decline in the Resident's decision of a resident mood by the resident mood by the resident mood by the resident or a symptom frequency of areas where behas being present a symptom increases (Behavior)Implementationing area whas independent, Su assistance since la improvement of resident manual (Finstrument) Version documents on pagis also appropriate of changes, with eidecline or two or manual (Finstrument)." On 8/10/16 at 5:50 Director of Nursing	p.m., RN #1, (Registered inurse) stated that a MDS was not done because	F 274	Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for furt audits and/or action plans. V Date of Compliance 9/16/2016	her	

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DEPARTMENT OF HEALTH AND HUM N SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

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STATEMENT OF DEFICIENCIES (X'AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
405044		B. WING	***************************************	С		
		495011			<u> 08/1</u>	1/2016
	PROVIDER OR SUPPLIER CARE HEALTH SERV			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
ı	the survey. 483.20(g) - (j) ASS ACCURACY/COO	tion was provided by the end of	F 274			
	resident's status. A registered nurse each assessment of participation of heat assessment is contained. A registered nurse assessment is contained. Each individual who assessment must at that portion of the attention of the	must conduct or coordinate with the appropriate alth professionals. must sign and certify that the appleted. o completes a portion of the sign and certify the accuracy of assessment. and Medicaid, an individual who agly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who agly causes another individual I and false statement in a ent is subject to a civil money e than \$5,000 for each		It is the practice of this facil to complete a complete and accurate Minimum Data Set (MDS) that accurately reflect the resident's status of our residents.	t	, to the second
	by: Based on staff inte	NT is not met as evidenced erview, facility documented record review, it was				

DEPARTMENT OF HEALTH	AND HUMAN SERVICES
CENTERS FOR MEDICARE	& MEDIO SERVICES
STATEMENT OF DEFICIENCIES	/X1) PROVIDER/SUPPLIER/CUA

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PRINTED: 08/18/2016 **FORM APPROVED** OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					SURVEY PLETED
		495011	B. WING				l	11/2016
	DER OR SUPPLIER HEALTH SERVI	CES-ALEXANDRIA		19	TREET ADDRESS, CITY, STATE, ZIP COD 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308	Ę		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
dete com assis surv. Res 1. R assis heigh MD: ARI records 2. F (MD refe char 7/18 heigh MD: ARI records 1. R assis heigh MD: ARI records Res 10/3	replete an accurate essment for threvey sample, Resident #5. Resident #5. Resident #5. Resident #6's finches (minimum data) (assessment orded a height of 65) assessment orded and height of 65) assessment orded and height of 65 and the Jessments recorded and the Jessment with an action of 65 inches (minimum data) (assessment with an action of 65 inches (minimum data) (min	at facility staff failed to ate MDS (minimum data set) are of 20 residents in the sident #7, Resident #6 and a for the resident. The quarterly as set) assessment, with an areference date) of 5/8/16 and a for the resident. The quarterly as set) assessment, with an areference date of 5/8/16 and the significant as ment, with an ARD of curately reflect the resident's and the January 28, 2016 and January 29, 2016 and January 30, 2016 quarterly MDS and January 30, 2016 quarterly January 30, 2016 quarterly January 30, 2016 quarterly January 30, 2016 quarterly 31, 2016 and 31, 31, 31, 31, 31, 31, 31, 31, 31, 31,	F2	278	The MDS for residents # and #5 have been correct 8/23/2016 to accurately the status of the resident	ted refl	on	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
	495011	B. WING		C 08/11/2016
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA			TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	33,11,2310
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
disease, difficulty hip. The resident's moset), a quarterly (assessment reforesident having a (brief interview for resident was more make daily decisor requiring the associated of daily living. The Kof the MDS as Review of Resides assessment with resident in Section he in height difference from MDS assessment of six months). An interview was p.m. with OSM (registered dietitic Section K of the When asked how entered, OSM # myself. The height software) from the populated into the importance of head ocumented, OS needs it would be and weight." When completing the section is the completion of the comp	page 28 sure, chronic obstructive lung y walking, anxiety and fractured lost recent MDS (minimum data assessment with an ARD erence date) of 5/8/16 coded the a nine out of 15 on the BIMS or mental status) indicating the derately impaired cognitively to sions. The resident was coded as sistance from staff for all activities he resident was coded in Section being 63 inches in height. ent #7's five day admission MDS han ARD of 11/6/15 coded the on K of the MDS as being 65 This was a two inch height the height coded on the quarterly hat with an ARD of 5/8/16 (a period so conducted on 8/10/16 at 1:50 other staff member) #6, the an. When asked who completed MDS, OSM #6 stated she did. W Resident's heights were stated, "I don't measure them of the nursing staff and it is auto he MDS." When asked the aving a correct height so M#6 stated, "For their energy he ideal to have the best height he MDS assessments, OSM #6 I (resident assessment	F 278	Residents residing in facility who require a Massessment have the potentiable affected by this alledeficient practice. Resident MDS were audited to enaccuracy of informasubmitted. Any errors for	IDS al to eged ents sure tion

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Event ID: CZ4K11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC. SERVICES

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PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495011	B, WING			1	C 11/2016	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA				1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308	1 001	1,2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 278	· · · · · · · · · · · · · · · · ·		F2	278	ш			
	p.m. with ASM (ad the director of nur- measured a reside they usually meas resident was lying height was correct stated, "I can't and one of the MDS as were correct, ASM that there are inact was acceptable, A ASM #2 stated, "V	conducted on 8/10/16 at 1:53 ministrative staff member) #2, sing. When asked how staff ent's height, ASM #2 stated that ure the height when the down. When asked which for Resident #7, ASM #2 swer that." When asked if either assessments for Resident #7 1 #2 stated, "There are times curacies." When asked if that asked if that asked if that asked if thook it (Resident #7's inches, I took it twice and got			Staffs responsible for the completion of the MDS will educated to follow the RAI manual guidelines when couthe MDS. The MDS Coordinator will audit MDS weekly and before submission the next 90 days to ensurproper coding has been entered.	ding S ions re		
	Medicaid) RAI ver Height and Weigh Quality of Life. Dir hydration status ca adversely affect he quality of life. Plan weight measurem the resident's nutr	S's (Centers for Medicare and sion 3.0 documented, "K0200: t. Item Rationale. Health-related ninished nutritional and an lead to debility that can ealth and safety as well as ming for Care. Height and ents assist staff with assessing ition and hydration status by anism for monitoring stability of od of time"						
	MEASUREMENT height is a necess energy requirement weight ranges."	lity's policy titled, "HEIGHT GUIDE. PURPOSE. Stature or ary parameter for determining nts and assessing desirable ation was obtained prior to exit.			IV The Administrator or Desig will review the results of th audits. Data collected will be	e		

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		AND HUMAN SERVICES		0	FORM	08/18/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		495011	B. WING			C 11/2016
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	ARE HEALTH SERVI	CES-ALEXANDRIA		510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON SHOUNDERSON SHOUNDERSON SHOWN SHO	JLD BE	(X5) COMPLETION DATE
F 278	2. Resident # 6's q (MDS) assessment reference date) of 5 change MDS asses 7/18/16, did not accheight. Resident # 6 was a 5/12/15 and readmithat included but we obstructive pulmonfractures (2), hyperbenign prostatic hyfailure (6), depressideficiency. Resident # 6's mos (minimum data set) assessment with ardate) of 7/18/16, co an 8 (eight) on the status (BIMS) of a seing moderately ir making daily decision as requiring extens dependent of one seing daily living. Review Weight" coded Resinches.	uarterly Minimum Data Set i, with an ARD (assessment 5/21/16, and the significant issment, with an ARD of curately reflect the resident's dmitted to the facility on itted on 7/11/16 with diagnoses ere not limited to: chronic ary disease (1), compression itension (3), dementia (4), perplasia (5), acute respiratory ion disorder and vitamin D It recent comprehensive MDS i), a significant change in ARD (assessment reference inded Resident # 6 as scoring brief interview for mental score of 0 - 15, 8 (eight) - inpaired of cognition for ions. Resident # 6 was coded ive assistance to being totally itaff member for activities of of Section K0200 "Height and ident # 6's height as 54	F 278	forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for fur audits and/or action plans V Date of compliance is September 16, 2016	d de de de de de de de de	
	assessment with ar	recent quarterly MDS n ARD of 5/21/16 coded bring an 11 on the brief				

height as 60 inches.

interview for mental status (BIMS) of a score of 0 - 15, 11- being moderately impaired in cognition for making daily decisions. Review of Section K0200 "Height and Weight" coded Resident # 6's

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495011	B. WING				C 11/2016
	PROVIDER OR SUPPLIEF	VICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CO 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD E	BE	(X5) COMPLETION DATE
F 278	On 8/10/16 at 1:4: conducted with Oregistered dieticia member) # 2, dire about the process height, OSM # 6 s (Point Click Care, nursing and auto the MDS." When discrepancies on change assessmenthe quarterly MDS 5/21/16, ASM # 2 discrepancy. I'll lo height." On 8/10/16 at 3:0: conducted with ASASM # 2 stated the re-measured by a herself revealing a asked which of Recorrect ASM # 2 sheight is based or time he was measusked to provide of 54, 60 and 58 is provide evidence status for each of unable to provide On 8/10/16 at 4:0: conducted with Ricoordinator. Whe discrepancies on change assessmenthe quarterly MDS 5/21/16 RN # 1 st	page 31 5 p.m., in an interview was SM (other staff member) # 6, in, and ASM (administrative staff ctor of nursing. When asked a for obtaining a resident's stated, "It's entered into PCC an electronic record system) by (automatically) populated into asked about the height Resident # 6's significant ent with an ARD of 7/18/16 and assessment with and ARD of stated, "I can't speak to the ok into it and get the correct 5 p.m. an interview was SM # 2, the director of nursing, he Resident # 6 was an aide, the unit manager and a height of 58 inches. When esident # 6's heights were stated, "They're all correct. The in the resident's status at the sured." ASM # 2 was then evidence that the three heights inches were correct and to of Resident # 6's change in the heights. ASM # 2 was any supportive documentation. 10 p.m. an interview was N (registered nurse) # 1, MDS on asked about the height Resident # 6's significant ent with an ARD of 7/18/16 and assessment with and ARD of ated, "It's really hard. I don't ked what policy they follow for	F 2	78			

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Event ID: CZ4K11

Facility ID: VA0177

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DEPARTMENT OF HEALTH AND HUMON SERVICES CENTERS FOR MEDICARE & MEDICON SERVICES

PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495011	B. WING_		I	C / 11/2016	
	PROVIDER OR SUPPLIER	VICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CO 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 278	the RAI (resident a manual." The RAI (Resident manual document K0200A, Height 1. Base height on the most recent as Measure and recordance with the which should reflet (shoes off, etc.). 3. For subsequent medical record. If more than one year resident's height at Con 8/10/16 at 5:50 member) # 1, the director of nursing findings. No further informating the survey. References: (1) A disease that can lead to shortness obtained from the survey.	DS, RN # 1 stated, "We follow assessment instrument) It Assessment Instrument It Instrum	F 2				
	(2) Broken verteb of the spine. This the website:	rae. Vertebrae are the bones information was obtained from us.gov/ency/article/000443.htm					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CZ4K11

Facility ID: VA0177

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

PRIN'	TED:	08/18/	2016
FC	DRM /	APPRO	VED
OMB	NO.	0938-0	0391

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	COM	E SURVEY MPLETED
		495011	B. WING			1	/11/2016
	PROVIDER OR SUPPLIER CARE HEALTH SERVI			1510	EET ADDRESS, CITY, STATE, ZIP CODE 0 COLLINGWOOD ROAD EXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (PROVIDER CORRECT))	O BE	(X5) COMPLETION DATE
F 278	Continued From pa	age 33	F 2	?78	•		
	obtained from the v	ssure. This information was website: nih.gov/medlineplus/highbloodp					
	that affect the brain obtained from the v	nptoms caused by disorders n. This information was website: nih.gov/medlineplus/dementia.h					
	obtained from the v	rostate. This information was website: nih.gov/medlineplus/enlargedpr					
	passes from your luinformation was ob	which not enough oxygen ungs into your blood. This btained from the website: h.gov/medlineplus/respiratoryfa					
	significant change I inches for the resid quarterly, and the J	5, the January 28, 2016 MDS recorded a height of 58 dent. The April 29, 2016 July 30, 2016 quarterly MDS rded the resident as 66 inches	2				
	diagnoses of but no cancer, psychosis,	dmitted on 6/16/15 with the ot limited to dementia, prostate obstructive uropathy, ion, high blood pressure, thube feeding.					
	The most recent M	IDS (Minimum Data Set) was a					

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

PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	СОМ	E SURVEY PLETED
		495011	B. WING		1	C 11/2016
	PROVIDER OR SUPPLIER	/ICES-ALEXANDRIA	1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309 SS=G	Reference Date) of coded as severely make daily life decopossible 15 on the Mental Status) example requiring total care extensive assistant assistance for transmoulation; and whad a catheter for A review of the Jarchange MDS assequarterly MDS assequarterly MDS assequarterly MDS assequarterly MDS assequarterly MDS record the April 29, 2016 was reviewed. The change MDS recorded the resident. The July 30, 2016 quarrecorded the resident. The July 30, 2016 quarrecorded the resident on 8/10/16 at 4:03 Nurse #1, the MDS know what happer On 8/10/16 at 5:50 Director of Nursing #2 and RN #3) we No further informating and RN #3) we No further informating the survey. 483.25 PROVIDE HIGHEST WELL Each resident musprovide the necessions.	ent with an ARD (Assessment of 7/30/16. The resident was cognitively impaired in ability to disions, scoring a 4 out of a BIMS (Brief Interview for am. The resident was coded as a for bathing and eating; ace for hygiene; limited asfers; supervision for as incontinent of bowel and bladder. The resident was coded as a for bathing and eating; ace for hygiene; limited asfers; supervision for as incontinent of bowel and bladder. The resident was coded as a for hygiene; limited as incontinent of bowel and bladder. The resident was coded as a service and the July 30 2016 and the July 30 2016 are serviced as a resident's height. In addition quarterly MDS assessment as a high service and the finding service and the 2 unit managers (RN	F 309			
	or maintain the nig	hest practicable physical,				

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Event ID: CZ4K11

Facility ID: VA0177

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICA

PRINTED: 08/18/2016 **FORM APPROVED** OMB NO. 0938-0391

	F CORRECTION	IDENTIFICATION NUMBER:	l ' '	i	СОМ	PLETED
	8	495011	B. WING		1	C 11/2016
	ROVIDER OR SUPPLIER	CES-ALEXANDRIA	'	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	1 001	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	mental, and psycholaccordance with the and plan of care. This REQUIREMENT by: Based on staff intereview, clinical recomplaint investigate the facility failed to wellness for one of sample, Resident #Facility staff failed to shoulder x-ray on 1 impacted humeral (fracture resulting in the resident treatment fracture. The findings include Resident #7 was accomplaint investigate the shoulder x-ray on 1 impacted humeral (fracture resulting in the resident treatment fracture). The findings include Resident #7 was accomplaint included the shoulder and readred the shoulder that the shoulder that the shoulder include the shoulder that the should the shoulder that the shoulder	NT is not met as evidenced erview, facility document and review and in the course of tion, it was determined that maintain the highest level of twenty residents in the survey er. o review Resident #7's right 1/13/15 which showed a supper arm bone) neck a three day delay in providing ent causing a decline in the	F 309	,		
	data set), a quarter (assessment refere resident having a n (brief interview for r resident was mode make daily decision	ly assessment with an ARD ence date) of 5/8/16 coded the ine out of 15 on the BIMS mental status) indicating the rately impaired cognitively to as. The resident was coded as ance from staff for all activities				·

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CZ4K11

Facility ID: VA0177



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC. SERVICES

	C /11/2016
495011 B. WING 08	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	-
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 Continued From page 36 Review of the care plan created on 10/30/15 and revised on 5/30/16 documented, "Focus. At risk for falls due to impaired balance/poor coordinationInterventions. Call light within reach with rapid response. Encourage/Assist to turn and reposition per resident's needs. Have commonly used articles within easy reach, low bed." Review of the fall assessment dated 10/30/15 at 2:20 p.m. documented in part, "Physical Performance Limitations. 4. Impaired balance during transitions. Disease & Conditions. 11. Decline in functional status. 20. Chronic or acute condition resulting in instability. 31. Impulsivity or poor safety awareness. No falls at this time fall precaution in place." Review of the occupational therapy notes dated 11/12/15 documented in part, "Stand from bed for repositioning, max (maximum) A (assistance)." Review of the nurse's notes dated 11/13/15 at 12:27 p.m. documented, "Extensive assistance with ADLS (activities of daily living) and transfers." Review of the facility's document titled, "STATEMENT" from LPN (licensed practical nurse) #7, the nurse caring for the resident, documented, "I was informed by the other nurse that this patient fell but has been assisted back to bed. So I asked the supervisor to assist me to assess this patient rupon arrival to patient room she started (sic) c/o (complain /of) severe pain to R (right) shoulder X-ray report documented, "Examination: SHOULDER COMPLETE. Conclusion: Acute or	

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

PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION		PLETED
		495011	B. WING			1	C / 11/2016
	PROVIDER OR SUPPLIER			15 ⁻	REET ADDRESS, CITY, STATE, ZIP CODE 10 COLLINGWOOD ROAD LEXANDRIA, VA 22308	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	D BE	(X5) COMPLETION DATE
F 309	subacute mildly im The report was fax 7:46 p.m. Review of the nurs 2:28 a.m. Res (res of the bed in front of asked (sic) she said herself from w/c ar her R (right) should was done no appa Res c/o pain on (si narcotic pain medi giving (sic) an orde x-ray." Review of the physical documentation reg Review of the nurs 8:12 p.m. document large bruise/edemi yesterday. Medical mouth) X (times) is the worst pain) p PRN (as needed). maintained." Review of the nurs 9:30 p.m. document bruised/edema. No ray. Safety/fall pres Review of the occu 11/16/15 document extremity) swelling (patient) c/o (comp motion) of elbow a	pacted humeral neck fracture." ed to the facility on 11/13/15 at e's notes dated 11/14/15 at ident) is (sic) sitting at the foot of her w/c (wheelchair) when id she was trying to transfer and lost her balance and fell on der Head to toe assessment rent injury noted at this time (c) shoulder Percocet (a cation (1)) 1 tab (tablet) was er received for R shoulder sician's notes did not evidence arding the x-ray results. e's notes dated 11/14/15 at anted, "Right shoulder noted a (swelling) s/p (status post) fall the with Percocet 1 tab po (by 1 for 7/10 (0 is no pain and ten the pain level with relief. Ice applied Safety/fall precautions e's notes dated 11/15/15 at anted, "Right shoulder remains of fx (fracture) per result of X cautions maintained. upational therapy notes dated ted, "R (right) UE (upper and bruising noted. Pt plained of) pain. ROM (range of ttempted. RN (registered quested x-ray. Pt has fx		309			

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Event ID: CZ4K11

Facility ID: VA0177

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		AND HUMAN SERVICES & MEDIO SERVICES			\bigcirc	FORM	: 08/18/2016 I APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		495011	B. WING			i i	C / 11/2016
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	ICES-ALEXANDRIA		15	REET ADDRESS, CITY, STATE, ZIP CODI 10 COLLINGWOOD ROAD LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 309	(fracture), being se Review of Resident dated, 11/16/15 doc Compared to the expreviously noted fra There is no evidence Fractures change prelationship." Review of the ement 11/16/15 at 2:04 p.i y.o. (years old) fem currently in rehab (rehab s/p (status popt (patient) was tryi fell. Patient current and severe pain wh Severity (of pain): r 6. Activities that wo Are symptoms wors Review of the ortho 11/16/15 document patient and family. Right upper extrement	at #7's right shoulder x-ray cumented, "Results: xamination 11/13/2015 the acture, has changed position. ce of healing. Conclusion: position into a less favorable argency room record dated m. documented in part, "96 ale h/o (history of) dementia rehabilitation) brought from the post of fall 3 days ago. Per family, and to get out of wheelchair but by has right arm ecchymosis aren moving right arm4. moderate, 5. Timing: constant.	F	809			

"STATEMENT" from OSM (other staff member) # 14, receptionist, documented in part, "Between 500-530 (5:00 p.m. to 5:30 p.m.) (name of resident) daughter called and said that she was talking to her mother on the phone and she said she needed help because she fell and she thinks she may have broken her shoulder....! spoke with (RN [registered nurse] #5, the nursing supervisor)

and told her what the daughter said."

Review of the facility's document titled,

DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDIC SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		СОМ	E SURVEY PLETED
		495011	B. WING			ı	C 11/2016
	PROVIDER OR SUPPLIER	/ICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		IN SHOULD E APPROPI	BE	(X5) COMPLETION DATE
F 309	documented, "Did resident) on 11/13 p.m.) shifts (sic)? involved in her car nurse taking care assess her, when complaining of pai immediately called X-ray while awaitin doctor What is to STAT x-ray? You give you a claim n fax confirmation wou do to follow up regardless of the refax. Did you call to follow up to call to follow up be incoming nurse? You have a company to call to follow up to call to follow up to call to follow up be incoming nurse? You was penicame in around 31 was negative. The	RN #5 dated 11/17/15 you work with (name of /15 at 3-11 (3:00 p.m. to 11:00 NO. How did you come re? I was the supervisor and of her called me to help her went there she was in to right shoulder. I If the doctor and I called for stating a call back from the he process when you call in a place a call in for order, they umber and then you wait for a re placed in the chart. What do results and then you to look into results and then you to look into results and then you give report to follow up with result? I didn't recauseDid you give report to foling. The following day when I recause the patient she in I assessed the patient she in she did on Friday"	F3	309			
	"STATEMENT" by documented, "On arrived on your 11 shift who gave you arrived, after I marked, after I marked, after I marked, which was she proceeded to fell and she has sushould, they have pain and an X-ray were negative for the actual x-ray re	lity's document titled, RN #4 dated 11/18/15 Friday 11/13/15 when you -7 (11:00 p.m. to 7:00 a.m.) I report about the unit? When I de my rounds I took report from the supervisor that evening, tell me that (name of resident) I ustained an injury to her right been (sic) medicated her for was ordered and the results any broken bones. Did you see sults? NO. did you call to follow the results with (name of x-ray)					

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

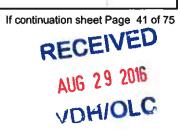
PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		DINGCOM		E SURVEY IPLETED	
		495011	B. WING			1	11/2016
	PROVIDER OR SUPPLIER CARE HEALTH SERVI			151	REET ADDRESS, CITY, STATE, ZIP CODE 10 COLLINGWOOD ROAD EXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	company)? NO." Review of the facilit "STATEMENT" by I dated documented (Resident #7) had it told me an x-ray wa according to her. He copain and their (shoulderThe fame the doctor." An interview was cop.m. with RN #5, the asked about the extensions and the assigned to her was her. So, we were to so we went there (It (LPN #7, the nurse know what to do so patient. I got the or called x-ray so they waiting for them to before they would for checked the fax maresults, RN #5 state admissions, I was or report at the end of follow up (on the x-report. The next danurse if we got the fracture, so I charted But I should have sword."	ty's document titled, RN #2, the unit manager, not, "She (RN #5) told me she fallen trying to transfer. She as done and was negative lowever she said the Pt. was sic) were swelling on that illy wanted her to be seen by onducted on 8/10/16 at 5:10 ne nursing supervisor. When vents related to Resident #7's N #5 stated, "I was supervisor on nurses and we had three by take a lot of work. The nurse is new and I was trying to help old that the patient had fallen to the resident's room). She is caring for the resident) didn't of I went there, I assessed the reder after I called the doctor. If y came and it was done. I was call me if there was a fracture fax it." When asked if she had achine for the shoulder x-ray ed, "There was a lot of doing a lot of stuff. I wrote the fithe shift and told them to the shift and told the shift and told the shift and told the shift and told the sh	F3	109			

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Event ID: CZ4K11

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DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDIC

PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTR			(X3) DATI COM	SURVEY PLETED
		495011	B. WING					C 11/2016
	PROVIDER OR SUPPLIEI CARE HEALTH SER	RICES-ALEXANDRIA		1510 COLL	DRESS, CITY, STATE, ZIP (LINGWOOD ROAD DRIA, VA 22308	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTION DSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
F 309	the director of nurevents related to Friday), ASM #2 sher shoulder and asked who was reresult, ASM #2 stresident, all of us. On 8/11/16 at 9:16 administrator and were made aware staff failing to follox-ray on 11/13/15 treatment and a dand ASM #2 were allegations at that An attempt to concared for Resider 8/11/16 at 9:28 a.	dministrative staff member) #2, sing. When asked about the Resident #7's fall on 11/13/15 (a stated, "On Monday I looked at said it didn't look right." When esponsible to check a stat x-ray ated, "The nurse caring for the " O a.m. ASM #1, the ASM #2, the director of nursing of the concern for harm due to be up on Resident #7's shoulder which created a delay in lecline in the fracture. ASM #1 made aware of the complaint	F	309				
	a.m. with LPN (lic When asked wha physician's order "When stat, says results work on it When asked if the results were not fo "No." An interview was a.m. with LPN #4 followed in regard stat x-ray, LPN #4	conducted on 8/11/16 at 10:10 ensed practical nurse) #3. It staff did in regards to a for a stat x-ray, LPN #3 stated, it all, it means now. When get right away and call the doctor." ere was any time stat x-ray ollowed up on, LPN #3 stated, conducted on 8/11/16 at 10:15. When asked the process staff its to a physician's order for a stated, "Means I have to have to call the radiology company for						

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

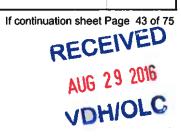
PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	, COV	TE SURVEY MPLETED
		495011	B. WING			1	C /11/2016
	PROVIDER OR SUPPLIER	VICES-ALEXANDRIA		151	REET ADDRESS, CITY, STATE, ZIP CODE O COLLINGWOOD ROAD EXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	going to do it stat. followed up in reg LPN #4 stated, "If check (the fax masometimes I even at 10:59 a.m. with assisted Resident asked what she re #7 sustained on 1 remember I wasn and get the patier was a problem the nurse who has got the results rigi we didn't get a cle on." When asked when a stat x-ray re supposed to chleave the building all over." An interview was a.m. with ASM #1 "When I found our PIP (performance was patient comfordermined from the stated, "We did not up on an x-ray in a concerned about with the supervisor care of the patient We have a plan of the supervisor care of the patient we have a plan of the supervisor care of the patient we have a plan of the supervisor care of the patient we have a plan of the supervisor care of the patient we have a plan of the patient was plan of the patient we have a plan of the patient was plan of the patient was a plan of the patient was plan of the patien	y and let them know we are "When asked how staff ards to getting the x-ray results, I have a stat order I always achine) frequently and call (the x-ray company)." view was conducted on 8/11/16 a LPN #6, the nurse who t #17 to bed after the fall. When ecalled about the fall Resident 1/13/15, LPN #6 stated, "I "ther nurse. I went to help her at to bed. We got an x-ray which I remember, honestly, oh boy, d the patient, I don't know if she ht away. Follow up was rough; ear picture of what was going what process staff followed was done, LPN #6 stated, you' neck on the x-ray before you I remember that day was busy conducted on 8/11/16 at 11:35 and ASM #2. ASM #2 stated, t about the issue, I initiated a a improvement plan). My priority ort." When asked what they the investigation, ASM #2 to follow our policy in following a timely manner. I was delay in treatment. I discussed it or and the actual nurse that took t and did immediate education. If correction in place to follow up	F3	09			
	company to notify	ts). We have asked the (x-ray) the DON (director of nursing) ator of all positive results. We					

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Event ID: CZ4K11

Facility ID: VA0177



DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDICARE & SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (X3) DATE SURVEY					
		495011	B. WING			1	C 11/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	001	11/2010
MANOR	CARE HEALTH SERV	ICES-ALEXANDRIA		1510 COLLINGWOOD ROA ALEXANDRIA, VA 2230			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	IN OF CORRECTION E ACTION SHOULD D TO THE APPROPI CIENCY)	BE	(X5) COMPLETION DATE
F 309	software) directly s computer it is right Review of the facilit documented, "Iden resident [Resident ordered stat. Resuld doctor) was not not patients in house has affected. Diagnosti house have been a current. System Corre-educated in lab process/Guidelines protocol. Copies of brought to the mormeeting to ensure been made. Monitodirectors) will do rafor 2 months to ensure been made. Monitodirectors) will do rafor 2 months to ensure been made. Identifit the facility QA commendations correction." A review of the facilit tracking forms reve of the residents' testing forms reve of the residents' testing forms reve of the residents' testing forms revents.	sults now come to (name of to when the nurse opens up the there." Ity's plan of correction tiffied Patient(s): (Name of #7]) fell on 11/13/15, X-ray Its received but MD (medical tified. Like Patients: Current have the potential to be corrected from Nov. 13 2015 until patients in audited from Nov. 13 2015 until prrection: All LPN/RN will be (laboratory) tracking so Staff discipline per facility if daily Diagnostic results will be ning QA (quality assurance) appropriate document has boring: DCDs (department care andom audits daily and monthly sure diagnostics results are in has been placed in chart. If 15/16. QAPI (quality lance improvement) and revisions to the plan of lility's laboratory and diagnostic arses was dated 11/20/15. Ity's laboratory and diagnostic called complete documentation	F3	309			
		FOR CLINICAL RECORD					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAL D' SERVICES

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	F CORRECTION	IDENTIFICATION NUMBER:	' '			MPLETED
		495011	B. WING		08	C 3/11/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		1172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 309	Reports. The findir ordered are retained record. When a last nurse reviews the minitials and dates the physician as clinically the physician as clinically the physician are provided and no control of the physician are considered and no control of the physician are reviewed and no control of the physician (Potter and was a reference so notification. Failured condition appropriation information to the physician are caused way to avoid being follow standards of care, and to comming providers. The physic responsible for confident of a patient. Past non compliant COMPLAINT DEFT (1) PERCOCET is of moderate to mode on ough to require a which alternative to the physician of the physician and the physician are considered to moderate to mode on the physician and the physician are considered to moderate to mod	nented, "Labs and Special ags for each lab or special test and in the patient's clinical or test result is received, a results, notes the findings, he report, contacts the ally indicated or as requested and enters a progress note." current residents were concerns were identified. tion was provided prior to exit. Essential for Practice, 6th Perry, 2007, pages 56-59), ource for physician's orders and a to monitor the patient's ately and communicate that onlysician or health care is of negligent acts. The best liable for negligence is to for care, to give competent health care is care, to give competent health care is care, to give competent health care in the provider directing the medical treatment	F 3			
			1			1

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Event ID: CZ4K11

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		E SURVEY IPLETED
			55.20		, <u></u>	,	С
		495011	B. WING	<u> </u>		08/	11/2016
•	PROVIDER OR SUPPLIEI CARE HEALTH SER	VICES-ALEXANDRIA		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312 SS=D	A resident who is daily living receive maintain good nut and oral hygiene. This REQUIREMI by: Based on observ document review, the course of a costaff failed to provresidents in the suffinger nails in a climater of the findings inclusion. The findings inclusion and reading that included but to obstructive pulmo fractures (2), hypobenign prostatic here.	unable to carry out activities of es the necessary services to trition, grooming, and personal ENT is not met as evidenced ation, staff interview, facility clinical record review, and in emplaint investigation, the facility ride nail care for one of 20 urvey sample, Resident # 6 to maintain Resident # 6's ean and neat manner.	F	312	F312 It is the practice of this facil to carry out activities of dail living for a resident who is dependent for care to receive the necessary services to maintain good nutrition, grooming, and personal and oral care.	y e	
	(minimum data se assessment with date) of 7/18/16, o an 8 (eight) on the status (BIMS) of a	est recent comprehensive MDS et), a significant change an ARD (assessment reference coded Resident # 6 as scoring e brief interview for mental a score of 0 - 15, 8 (eight) -			I Corrective Action The fingernails of Resident have been clipped, cleaned.		

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making daily decisions. Resident # 6 was coded

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	OF CORRECTION	IDENTIFICATION NUMBER:	450	E CONSTRUCTION	COMPLETED
		495011	B WING		08/11/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	31
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 312	as requiring extens dependent of one staily living. Reside "Occasionally inconti "Frequently inconti On 8/9/16 at 1:40 president # 6 revea Further observation on his right and lef brown substances	sive assistance to being totally staff member for activities of ent # 6 was coded as being nationent" of bowel and nent" of bladder. o.m. an observation of alled he was lying in bed awake. In of Resident # 6's finger nails thands revealed black and under all his finger nails and all ped, cracked and extended	F 312	now remain neat. Other residents' fingernails were maintained in a neat manne	i i
	Resident # 6 reveal Further observation on his right and left brown substances the nails were chip beyond the ends of the nails were chip beyond the samining Resider and in need of the nails were carried that Resided the nails were complianted to the nails were chip beyond the nails w	p.m. an observation of er nails was conducted with sing assistant) # 9. After nt # 6's finger nails CNA # 9 ent #6's nails were long, dirty		II Identification All residents residing in the facility who require dependence the potential to be affected by the alleged definition practice.	dent e

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			СОМ	ATE SURVEY OMPLETED	
		495011	B. WING	_		1	11/2016	
	PROVIDER OR SUPPLIER	/ICES-ALEXANDRIA		1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	Continued From page 47 about nail care for Resident # 6, LPN # 2 stated, "Finger nails are cut when they are long and cleaned every day. Sometimes staff will clean			312	III Systematic Changes The Administrator or Desig	nee		
	and cut his nails. I don't know the last time his nails were cleaned and cut." The care plan for Resident # 6 dated 6/15/2016 documented, "Focus: Resistive/noncompliant w				will re-educate staff on maintaining residents' fingernails in a clean and ne			
	room cleaned, thro toilet room r/t (rela "Intervention" it do in ADL (activities of accommodate mo routine; Elicit famili ask physician to e	uses showers, refuses to have ows paper towels on the floor in ited to): dementia." Under cumented, "Allow for flexibility of daily living) routine to od, preferences and customary ly input for best approaches; xplain/reinforce need for s care, leave (if safe to do so)			manner.			
	5/12/15 through 8/	tes" for Resident # 6 dated /5/16 failed to evidence Resident # 6's refusal of finger		10				
	conducted with CN 6 regarding cleani residents'. CNA # resident isn't a dia Hands are examir and if needed it is resident refuses, t	is a.m. an interview was NA (certified nursing assistant) # ng and cutting finger nails for 6 stated, "CNAs do it if the betic. It's done as needed. Hed during A.M. (morning) care done during care. If the ry to explain the reason for care fuses I notify the nurse and try	sistant) # ails for f the ded. ag) care e n for care and try		IV Monitoring The Director of Nursing (Do or Designee will audit nail of residents weekly for 4 we and monthly for 2 months.	eare eeks		
	conducted with RI regarding cleaning	a.m. an interview was (registered nurse) # 4 (and cutting finger nails for (stated, "CNAs do it during			Administrator will do a rand spot check for an additional	dom		

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	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l''		E CONSTRUCTION	СОМ	E SURVEY PLETED
		495011	B. WING	_			C 11/2016
	PROVIDER OR SUPPLIER CARE HEALTH SERV			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD ILEXANDRIA, VA 22308	, 00/	1172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE .	(X5) COMPLETION DATE
F 312	resident daily durin responsibility of all try to explain the incare. If the resider the nurse's notes a responsible party." On 8/11/16 at 9:30 conducted with CN cutting of finger na stated, "CNAs are needed." When as resident's finger na CNA # 1 stated, "C daily care. If they routing finger nail fo "CNAs clean and cevery day." On 8/11/16 at 10:15 conducted with LPI cutting finger nail fo "CNAs clean and cevery day." On 8/11/16 at 10:15 conducted with ASI member) # 2, the coleaning and cuttin ASM # 2 stated, "It and nurses. It's do basis. If they refuse continue to refuse asked if the resider documented, ASM documented." Wherefusal would not be stated, "It would be required." When a finger nails not beir	r responsibility to check the g care and it's the shifts. If the resident refuses I apportance and reason for nail at still refuses I document it in and notify the physician and	F	312	week for compliance. Data collected will be forwarded Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for furth audits and/or action plans. V Date of Compliance 9/16/2016		

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495011	B. WING		<u></u>	ı	C 11/2016
NAME OF F	PROVIDER OR SUPPLIER		T	S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 00/	11/2010
MANORO	CARE HEALTH SERV	CES-ALEXANDRIA		1	510 COLLINGWOOD ROAD		
	DAKE HEALIH GEKV	OLO-ALEXANDINA		A	LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 49	F 3	12			
	know if he refused to document refusa	because it's not a requirement Il of nail care."					
		"Nail Care" documented, le for personal hygiene needs on."					
	member) # 1, the a	p.m. ASM (administrative staff dministrator, and ASM # 2, the were made aware of the					
	No further informati	ion was provided prior to exit.					
	Patricia A. Potter ar Inc; Page 863, doci a very basic part of practices help to all	ursing, 7th edition, 2009; and Anne Griffin Perry; Mosby, uments, "Providing hygiene is a client's care. Caring eviate the client's anxiety and and relaxation while performing sure."	*				
	can lead to shortne was obtained from	makes it difficult to breath that ss of breath. This information the website: ih.gov/medlineplus/copd.html>					
	of the spine. This is the website:	ae. Vertebrae are the bones information was obtained from s.gov/ency/article/000443.htm					
	obtained from the v	ssure. This information was vebsite: ih.gov/medlineplus/highbloodp				95	

DEPARTMENT OF HEALTH AND HUIM	N SERVICES
CENTERS FOR MEDICARE & MEDIC.	SERVICES

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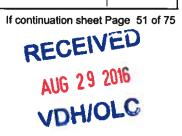
PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495011	B. WING _		C 08/11/2016
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA				STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	00/11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 312	ressure.html>. (4) A group of symthat affect the brain obtained from the v	ptoms caused by disorders . This information was	F 31	2	
	(5) An enlarged probtained from the vehttps://www.nlm.nostatebph.html>. (6) A condition in vehttpasses from your leinformation was ob	ostate. This information was vebsite: ih.gov/medlineplus/enlargedpr which not enough oxygen ungs into your blood. This tained from the website: n.gov/medlineplus/respiratoryfa			
F 315 SS=D	Based on the residence assessment, the faresident who enters indwelling catheter	HETER, PREVENT UTI,	F 31	F315	
	catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:			It is the practice of this facility to ensure that a resident who enters the facility without a indwelling catheter is not catheterized unless the residulinical condition demonstration.	ents ited
	Based on observa	tion, staff interview, facility		that need; and a resident who	O 1S

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDEATIFICATION NUMBER.		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						I	С
		495011	B. WING			08/	/11/2016
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA			1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	document review, course of complain determined that the Foley care in a material one of 20 resident Resident #4.	clinical record review and in the nt investigation, it was e facility staff failed to provide unner to prevent infection for s in the survey sample, I to keep Resident #4's Foley the floor.	F3	315	incontinent of bladder receivappropriate treatment and services to prevent urinary trinfections and to restore as much normal bladder functions as possible.	ract	
	and readmitted on included but were muscle weakness, and elevated chole. The most recent of quarterly assessm reference date of 6 being severely implecisions. The result assistance for all a resident was code. An observation of 8/10/16 at 9:30 a.r. on her right side whag was on the left bag was in a prival approximately ten lying directly on the An observation of	ADS (minimum data set), a ent, with an assessment 6/6/16 coded the resident as paired cognitively to make daily ident was coded requiring staff activities of daily living. The das having a urinary catheter. Resident #4 was made on m. The resident was lying in bed ith her eyes closed. The Foley to side of the bed. The Foley cy bag, the bag and inches of the Foley tubing were a floor. Resident #4 was made on			Corrective Action The Foley catheter tubing arbag of resident #4 was immediately removed from touching the floor. Upon the staff being aware of the issuall other residents with foley catheters in the facility were audited immediately for correction of the alleged deficient practice. I Identification	e, /	
	8/10/16 at 11:20 at the bed on her right propped behind he	m. The resident was lying in nt side with a long pillow er back. The Foley bag and nt inches of the tubing were			All the residents who reside the facility that have indwell		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1.0	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495011	B, WING	•			0
*****		495011	B, WING	`		08/	11/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	ICES-ALEXANDRIA			510 COLLINGWOOD ROAD		
				Α	LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315		_	F3	315	Foley catheters have the		
	lying directly on the	floor.			potential to be affected by the	nis	
					alleged deficient practice		
		s made on 8/10/16 at 11:22			_		
		nsed practical nurse) #4, the eresident. When asked to			(8/10/16).		
		g, LPN #4 raised the height of					
		foley bag and tubing off the					
		what she had seen, LPN #4					
		was in the privacy bag and the					
		as on the floor. When asked if					
		the floor LPN #4 stated, "A			III		
		g there, um hum." When eptable for the Foley bag and			Systematic Changes		
		on the floor, LPN #4 stated,					
		issue." When asked if she			The DON or Designee will a		
		oley bag that day, LPN #4			_		
		t at the beginning of my shift."			educate the clinical staff on	tne	
		the resident usually had a			proper handling of Foley		
h		ut she was going to be in later ad been checking on Resident			catheters, to include resting	on	
	#4 every 45 minute				the floor. Other non-clinical		
	,				staff members will also be		
		ician's orders dated on signed					
	on 7/21/16 docume				educated to reinforce the		
		EY CATHETER #16F liters) STRAIGHT TO			observation and reporting of		
	GRAVITY DRAINA				potential noncompliance of	the	
					alleged deficient practice.		
		st 2016 MAR, medication			3 p		
	administration reco						
		EY CATHETER #16F/10ML					
	STRAIGHT TO GR	AVITY DRAINAGE"			IV		
	Review of Resident	#4's care plan created on			Monitoring		
		d on 7/18/16 documented in					
Tit.	part, "Use of indwel	lling urinary catheterReport			The DON or Designee will		
		of UTI (urinary tract infection)			_		
		dy urine, fever, increased			audit Foley catheter handling	g	
	restlessness, lethar	gy, c/o (complaints of)					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLETED
		495011	B. WING		08/1	; 1/2016
	PROVIDER OR SUPPLIER	CEC ALEVANIDOIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD	1 00/1	172010
WANOR	CARE HEALIN SERVI	CES-ALEXANDRIA		ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	pain/burning." An interview was cop.m. with RN (regis manager. When as Foley bag and tubir #3 stated, "It's an inshould be touching changed the whole #3 was made award. An interview was coa.m. with ASM (adnothed director of nursi acceptable for a Foon the floor, ASM # control issue." ASM ASM #2 were made time.	onducted on 8/10/16 at 5:05 tered nurse) #3, the unit ked if it was acceptable for a ag to be lying on the floor, RN affection control thing, nothing the floor. I would have thing (bag and tubing)." RN are of the findings. Onducted on 8/11/16 at 11:40 ministrative staff member) #2, ang. When asked if it was ley bag and tubing to be lying 2 stated, "It's an infection I #1, the administrator and a aware of the findings at that	F 315	weekly for 4 weeks and monthly for 2 months. Data collected will be forwarded Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for furth audits and/or action plans.	to	
	additional information No further information COMPLAINT DEFINATION NEEDS The facility must emproper treatment and special services: Injections; Parenteral and entertain needs of the services of the service	con was provided prior to exit. CIENCY ENT/CARE FOR SPECIAL sure that residents receive and care for the following eral fluids; stomy, or ileostomy care;	F 328	V Date of Compliance 9/16/2016		

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA (X4) ID PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 328 Continued From page 54 Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by:		I OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
MANORCARE HEALTH SERVICES-ALEXANDRIA (X4) ID PREFIX TAG F 328 Continued From page 54 Foot care; and Prostheses. STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308 PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 328			495011	B. WING_		C 08/11/2016
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 328 Continued From page 54 Foot care; and Prostheses. This REQUIREMENT is not met as evidenced			ICES-ALEXANDRIA		1510 COLLINGWOOD ROAD	
Foot care; and Prostheses. This REQUIREMENT is not met as evidenced	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROPRIES	D BE COMPLETION
Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide podiatry services for one of 20 residents in the survey sample, Resident # 6 stoe nails in a clean and neat manner. The findings include: It is the practice of this facility to ensure that residents receive proper treatment and care for the following special services: Injections, parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; tracheostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prosthesis.	F 328	Foot care; and Prostheses. This REQUIREMED by: Based on observation document review, of the course of a constaff failed to provid 20 residents in the Facility staff failed to nails in a clean and The findings included Resident # 6 was a 5/12/15 and readment that included but we obstructive pulmon fractures (2), hyper benign prostatic hy failure (6), depress deficiency. Resident # 6's most	NT is not met as evidenced tion, staff interview, facility clinical record review, and in inplaint investigation, the facility de podiatry services for one of survey sample, Resident # 6 to maintain Resident # 6's toe dineat manner. e: admitted to the facility on itted on 7/11/16 with diagnoses ere not limited to: chronic lary disease (1), compression tension (3), dementia (4), perplasia (5), acute respiratory ion disorder and vitamin D	F 32	F328 It is the practice of this faci to ensure that residents receptoper treatment and care for the following special service Injections, parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; tracheal suctioning; respirate	eive or es:
assessment with an ARD (assessment reference date) of 7/18/16, coded Resident # 6 as scoring an 8 (eight) on the brief interview for mental status (BIMS) of a score of 0 - 15, 8 (eight) - being moderately impaired of cognition for making daily decisions. Resident # 6 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living. On 8/9/16 at 1:40 p.m. an observation of		assessment with an date) of 7/18/16, co an 8 (eight) on the status (BIMS) of a being moderately ir making daily decisi as requiring extens dependent of one statily living.	n ARD (assessment reference oded Resident # 6 as scoring brief interview for mental score of 0 - 15, 8 (eight) - mpaired of cognition for ons. Resident # 6 was coded live assistance to being totally staff member for activities of	114444		

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

PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		SURVEY
				•			
		495011	B. WING			08/·	11/2016
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA		CES-ALEXANDRIA		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308		_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	Further observation revealed the secon the right and left fed quarter inch past the On 8/10/16 at 4:00 Resident # 6 reveal Further observation revealed the secon the right and left fed quarter inch past the On 8/10/16 at 4:15 Resident # 6's toe of (certified nursing as Resident # 6's toe of Resident # 6's toe of Resident # 6's toe of (licensed practical of Resident # 6's toe of (licensed practical of Resident # 6's toe of Resident # 6's	ed he was lying in bed awake. of Resident # 6's feet d, third and fourth toe nails on et were approximately a e end of each toe. p.m. an observation of ed he was lying in bed awake. of Resident # 6's feet d, third and fourth toe nails on et were approximately a	F3	3328	I Corrective Action The toenails of resident #6 has been cleaned and neatly maintained on the day the alleged deficient practice was notified to the facility. All or residents' toenails have also been audited and treated as necessary. II Identification	is ther	
	documented, "Focu treatment/care refu	tesident # 6 dated 6/15/2016 s: Resistive/noncompliant with ses showers, refuses to have			All the residents residing in facility have the potential to		

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toilet room r/t (related to): dementia." Under

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			20.	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495011	B. WING		C 08/11/2016	
	PROVIDER OR SUPPLIE	RVICES-ALEXANDRIA	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	1 00/1	1/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(X5) COMPLETION DATE
F 328	"Interventions" it in ADL (activities accommodate m routine; Elicit farmask physician to treatment; If resist and return later." Review of Reside a "Podiatric Servi Further review of revealed Resider on 5/17/16. It do symptomatic. Dy (ingrown) nails. The "Progress No"05/17/2016" doc by the Podiatrist 's note stable, no distress Podiatrist 's note stable, no distress On 8/11/16 facilit with a copy of a "08/10/2016" revepodiatry services. The "Progress No 8/11/2016 at 7:34 was seen by the evening shift. See Review of Reside a "Podiatric Servi Further review of revealed Resider on 8/10/16. It do	documented, "Allow for flexibility of daily living) routine to cod, preferences and customary lily input for best approaches; explain/reinforce need for sts care, leave (if safe to do so) ent # 6's clinical record revealed ices Report" dated "05/17/2016." Ithe "Podiatric Services Report" at # 6 received podiatry service cumented, "Debrided (removed) strophic (affected). Inncurvated otes" for Resident # 6 dated numented, "Resident was seen today, please see chart for es/orders. Resident remains sonted. " The staff provided this surveyor Podiatric Services Report" dated numented in the services Report of the surveyor Podiatric Services Report of the services Report of the surveyor Podiatric Services Report of the services Report of the surveyor Podiatric Services Report of the services Report of the services of the surveyor Podiatric Services Report of the services of the surveyor of the services of the surveyor of the services o	F 328	III Systematic Changes The ADNS or designee will conduct an educational revie for the nursing aides on the provision of providing nail of to the residents and placing residents on the podiatry list needed. If the patient refuse nail care, the proper documentation will be colle and the patient will be reapproached on the following visit by the Podiatrist.	ew care the t as es	

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Event ID: CZ4K11

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DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDIC. ... D SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ´	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495011	B. WING		C 08/11/2	2016
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE CO	(X5) IMPLETION DATE
F 328	5/12/15 through 8/5 documentation of Finail care. On 8/11/16 at 9:45 conducted with LPN for residents. LPN by the podiatrist." On 8/11/16 at 10:15 conducted with ASM member) # 2, the doto nail care. When are seen by the podiatrist of the facility." When to have the podiatrist between May 17, ASM # 2 stated, "I to documentation." On 8/11/16 at 10:45 conducted with ASM and OSM (other state social services. ASM that Resident # 6 with the podiatrist on 7/10 of residents that we on 7/19/16, OSM # sheets, I don't have Resident # 6 wasn't 7/19/16, ASM # 2 was to why Resident asked about the donot being seen on 7/10 services. The conducted with the donot being seen on 7/10 services. ASM # 2 was to why Resident asked about the donot being seen on 7/10 services.	ge 57 ges" for Resident # 6 dated i/16 failed to evidence desident # 6's refusal of toe a.m. an interview was if 5 regarding toe nail care if 5 stated, "Toe nails are done if a.m. an interview was if (administrative staff irector of nursing regarding in asked how often residents' diatrist, ASM # 2 stated, derly or as needed. When he is podiatrist sees everyone in asked if there was an attempt st come in and see Resident # 2016 and August 10, 2016, hink so. There should be if a.m. an interview was if member) # 2, director of if member) # 2, director of if member) # 2, director of if member) # 2 stated as scheduled to be seen by if member) # 2 stated as scheduled to be seen by if member in asked for the list if to be seen by the podiatrist if it is a list." When asked why if seen by the podiatrist on if it is a list." When asked why if seen by the podiatrist on if it is a list. If it is it is an it say it was done."	F 328	IV Monitoring The DON or Designee will audit residents' nails weekly 4 weeks and monthly for 2 months for neatness of residents' nails. Data collecte will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.	ed	

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

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495011	B. WING			C 08/11/2016		
	PROVIDER OR SUPPLIER	/ICES-ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			1 007	11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ŧ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 328	The facility's polici "Purpose: To stim control odor and of toe nails and apply feet. Do not apply THAT IS DIABETI vascular disease) nails (only license On 8/10/16 at 5:5 member) # 1, the director of nursing findings. No further informate Fundamentals of Patricia A. Potter at Inc; Page 863, do a very basic part of practices help to a promote comfort at each hygiene mean References: (1) A disease that can lead to shorter was obtained from	y "Foot Care" documented, ulate peripheral circulation, observe for infection. 11. Trim y lotion to tops and soles of between the toes. PATIENT C WITH PVD (peripheral DIAGNOSIS: 4. Do not cut toes d nurses)." O p.m. ASM (administrative staff administrator, and ASM # 2, the were made aware of the attion was provided prior to exit. Nursing, 7th edition, 2009; and Anne Griffin Perry; Mosby, cuments, "Providing hygiene is of a client's care. Caring alleviate the client's anxiety and and relaxation while performing asure."		328	V Date of Compliance 9/16/2016			
	of the spine. This the website:	orae. Vertebrae are the bones information was obtained from us.gov/ency/article/000443.htm						
	(3) High blood pro	essure. This information was						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495011	B. WING		08/11/2016		
	PROVIDER OR SUPPLIER	ICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 328	Continued From pa obtained from the v https://www.nlm.nressure.html .	-	F 328	3			
, ,	that affect the brain obtained from the	ptoms caused by disorders This information was website: ih.gov/medlineplus/dementia.h					
	obtained from the	ostate. This information was vebsite: ih.gov/medlineplus/enlargedpr					
	passes from your li information was ob	which not enough oxygen ungs into your blood. This tained from the website: n.gov/medlineplus/respiratoryfa					
	COMPLAINT DEFI 483.65 INFECTION SPREAD, LINENS	CIENCY N CONTROL, PREVENT	F 44				
	Infection Control Pasafe, sanitary and	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction.		F441			
	Program under whi (1) Investigates, co in the facility; (2) Decides what p	stablish an Infection Control		It is the facility's practice to establish and maintain an infection control program designed to provide a safe,			

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PRINTED: 08/18/2016 DEPARTMENT OF HEALTH AND HU! **FORM APPROVED** CENTERS FOR MEDICARE & MEDIO OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495011 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD MANORCARE HEALTH SERVICES-ALEXANDRIA **ALEXANDRIA, VA 22308** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 441 Continued From page 60 sanitary and comfortable (3) Maintains a record of incidents and corrective environment and to prevent the actions related to infections. development and transmission of disease and infection; (b) Preventing Spread of Infection (1) When the Infection Control Program establish an infection control determines that a resident needs isolation to program under which it prevent the spread of infection, the facility must isolate the resident. investigates, controls and (2) The facility must prohibit employees with a prevents infections in the communicable disease or infected skin lesions from direct contact with residents or their food, if facility; decides what direct contact will transmit the disease. procedures, such as isolation, (3) The facility must require staff to wash their should be applied to an hands after each direct resident contact for which hand washing is indicated by accepted individual resident; and professional practice. maintains a record of incidents (c) Linens and corrective actions related to Personnel must handle, store, process and infections. transport linens so as to prevent the spread of It is also the facility's practice infection. to handle, store, process and transport linens so as to prevent This REQUIREMENT is not met as evidenced the spread of infection. Based on observation, staff interview, facility document review, clinical record review and in the

1. Facility staff failed to keep Resident #4's Foley bag and tubing off the floor.

course of complaint investigation, it was

determined that the facility staff failed to provide Foley care in a manner to prevent infection for one of 20 residents in the survey sample,

Resident #4 and failed to maintain clean linen in a

2. Facility staff failed to maintain clean air

Corrective Actions

The Foley bag and tubing of resident #4 no longer touches

sanitary manner.

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		495011	B. WING			08/11/2016	
	PROVIDER OR SUPPLIER CARE HEALTH SER	/ICES-ALEXANDRIA		1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	The findings included and tubing off Resident #4 was a and readmitted on included but were muscle weakness and elevated choled. The most recent included by the most recen	in the clean laundry room area. de: ed to keep Resident #4's Foley the floor. admitted to the facility on 9/9/15 11/7/15 with diagnoses that not limited to: dementia, high blood pressure, arthritis	F	441	the floor. The alleged defici practice was corrected on 8/10/16. An audit of all the residents with indwelling For catheters was completed, and no new findings identified. The air conditioning vents is the laundry room were thoroughly cleaned and clear air conditioning vents are no maintained in the laundry roand in other areas of the facility.	oley nd n n ow	
	An observation of Resident #4 was made on 8/10/16 at 9:30 a.m. The resident was lying in bed on her right side with her eyes closed. The Foley bag was on the left side of the bed. The Foley bag was in a privacy bag, the bag and approximately ten inches of the Foley tubing were lying directly on the floor. An observation of Resident #4 was made on 8/10/16 at 11:20 a.m. The resident was lying in the bed on her right side with a long pillow propped behind her back. The Foley bag and approximately eight inches of the tubing were lying directly on the floor. An observation was made on 8/10/16 at 11:22 a.m. with LPN (licensed practical nurse) #4, the				II Identification All the residents in the facil with indwelling Foley cathe have the potential to be affe by the alleged deficient practice.	ters	

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nurse caring for the resident. When asked to

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.22		· · · · · · · · · · · · · · · · · · ·	c	
		495011	B. WING			08/	11/2016
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-ALEXANDRIA		1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308		
(X4) ID PREFIX			IĐ	ID PROVIDER'S PLAN OF CORRECTION			(X5)
TAG		SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
F 441	the bed to get the floor. When asked stated, "The Foley bed was low so it was there was tubing o little bit was dangli asked if it was accubing to be directl "No, it's an infection had checked the F stated, "I checked LPN #4 stated that private caregiver be	ag, LPN #4 raised the height of Foley bag and tubing off the what she had seen, LPN #4 was in the privacy bag and the vas on the floor. When asked if in the floor LPN #4 stated, "A ng there, um hum." When eptable for the Foley bag and y on the floor, LPN #4 stated, in issue." When asked if she oley bag that day, LPN #4 it at the beginning of my shift." It the resident usually had a ut she was going to be in later and been checking on Resident	F	141	All the residents residing in facility whose laundry is do in the facility have the poter to be affected by this alleged deficient practice.	ne itial	
	Review of the physician's orders dated on signed on 7/21/16 documented, "09/10/15: INDWELLING FOLEY CATHETER #16F (french)/10ML (milliliters) STRAIGHT TO GRAVITY DRAINAGE" Review of the August 2016 MAR, medication administration record, documented, INDWELLING FOLEY CATHETER #16F/10ML				III Systemic Changes The clinical staff will be reeducated by the DON or	•	
	STRAIGHT TO GF Review of Resident 9/10/15 and revise part, "Use of indwe to physician signs such as blood, clou- restlessness, lethat pain/burning." An interview was co	RAVITY DRAINAGE" It #4's care plan created on d on 7/18/16 documented in elling urinary catheterReport of UTI (urinary tract infection) ady urine, fever, increased rgy, c/o (complaints of) onducted on 8/10/16 at 5:05			designee on catheter care an treatment. The Maintenance Director a the laundry staff will be reeducated on the procedure keeping air conditioning ver clean, to include the laundry area. A weekly air condition	nd of ats	

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manager. When asked if it was acceptable for a

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495011	B. WING _			C 11/2016	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 441	Foley bag and tubin #3 stated, "It's an in should be touching changed the whole #3 was made awar. An interview was caum. with ASM (adrithe director of nurs acceptable for a Foon the floor, ASM # control issue." ASM ASM #2 were made time. Review of the facilia additional informatic	ing to be lying on the floor, RN infection control thing, nothing the floor. I would have thing (bag and tubing)." RN is of the findings. Inducted on 8/11/16 at 11:40 ininistrative staff member) #2, ing. When asked if it was alley bag and tubing to be lying it is 2 stated, "It's an infection in #1, the administrator and it is aware of the findings at that ity's policy did not reveal	F 44	vent cleaning schedule and signing sheet have been initiated at this time. IV Monitoring	_ = +		
	On 8/11/16 at approach the facility's laundry OSM (other staff maintenance and Chousekeeping and clean laundry room conditioner ducts minches long by 12 in	ed to maintain clean air in the clean laundry room area. eximately 11:15 a.m. a tour of it room was conducted with ember) # 11, director of laundry. Observation of the area revealed two air neasuring approximately 12 inches wide located on the nall four sides of both ducts.		The DON or designee will weekly audit of all Foley catheters for proper care at treatment for four weeks at monthly for two months ar forward findings to the Qu and Assurance Committee. The Maintenance Director designee will complete a weekly audit of air conditions, to include the laundary	nd nd ality or		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES						FORM.	08/18/2016 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495011	B. WING			l	C 11/ 2016
MANORCARE HEALTH SERVICES-ALEXANDRIA		CES-ALEXANDRIA		15	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Cold air was blowin four sides of the air Observation of the covered with dust at the clean laundry are linen racks partially and two uncovered unfolded linens. The through the dirty and linen carts of clean OSM # 11 and OSM responsible for clean OSM # 11 stated, "I stated, "We clean the clean linen OSM cleaned." The facility's policy documented in part assist laundry staff laundry area and expenses and dust once a ween on 8/11/16 at 12:05 staff member) # 1, 1 aware of the finding	g from each of the vents on all conditioning ducts. Vents revealed they were nd dirt. Further observation of rea revealed three uncovered filled with clean folded linen rolling linen carts with clean the cold air was blowing air did dusty vents over the five linen. If # 12 were asked who was uning the air conditioner vents, the OSM # 12." OSM # 12 he vents once a week." When the vents above the carts with If # 12 stated, "They should be "Cleaning Guidelines", "The following guidelines with routine cleaning of the quipment: ceiling vents, floor are cleaned to remove lint ek." If p.m. ASM (administrative the administrator, was made	F 4	141	cleanliness for four weeks a monthly for two months. Da collected will be forwarded Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for furth audits and/or action plans. V Date of Compliance 9/16/2016	ita to	
	COMPLAINT DEFIG 483.75(I)(1) RES RECORDS-COMPL LE	CIENCY LETE/ACCURATE/ACCESSIB	F 5	514			

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DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARE & MEDICARE

PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495011	B. WING _		C 08/11/2016		
	PROVIDER OR SUPPLIER	CES-ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		1 00/	11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE	(X5) COMPLETION DATE	
F 514	resident in accorda standards and prace accurately document systematically organ. The clinical record a information to ident resident's assessm services provided; the preadmission screet and progress notes. This REQUIREMENT by: Based on staff intered and facility document that the facility staff and accurate clinical residents in the surform, # 10 and # 5. 1. The facility staff of Resident's name are 9's clinical record. 2. Facility staff failed durable do not resurted.	aintain clinical records on each nee with accepted professional tices that are complete; nted; readily accessible; and nized. must contain sufficient ify the resident; a record of the ents; the plan of care and he results of any ening conducted by the State;	F 51		on are aible,		
		ailed to complete the "Durable Order" (DDNR) for Resident					
	4. For Resident #5, was filed on the clin	another resident's information ical record.		Ģ.			

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURV	
		495011	B. WING		مر	C /11/ 2016
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		/11/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 514	Continued From	page 66	F 5	14		
	Resident's name 9's clinical record Resident # 9 was with diagnoses the to: seizure disord depression, coror gastroesophagean neuropathy. Resident # 9's moset) assessment, an ARD (assessment, an ARD (assessment # as able to undersecoded on the BIM Status) with a second that the Resident Review of Resident	f documented another and room number in Resident #		The clinical records for residents #9, #7, #10, have all been audited DON and are now contant accurate. The resident's name to documented in the clinecord of resident #9 struck out on 8/25/16. The DDNR form for a #7 has been complete reflect the resident's	or and #5 by the mplete hat was nical has been resident	
	"5/22/16At 064 to Resident (the FResident # 9) in rResident in listed During an intervieus LPN (licensed praasked if one could name and room rLPN # 3 stated the	5am (6:45 a.m.) I was attending Resident identified was not com (number listed) (name of room)" ew on 8/10/16 at 2:50 p.m. with actical nurse) # 3, LPN # 3 was d document another resident's number in a resident's chart. at one could identify the room rethe name of another resident in		The DDNR order for #10 has been complet (8/10/16). The information of an resident that was filed clinical record of resident.	resident red nother I on the	

During an interview on 8/10/16 at 2:55 p.m. with

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495011	B. WING			08/	11/2016
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA		ICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZI 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 514	LPN # 4, LPN # 4 vidocument another number is a resider one could document but not the name of the director of nurses above mentioned of (nurses note) with a room number in Restated, "The nurse another resident in the room number is ASM # 2 was asked policy, ASM # 2 stawas just a "best praasked what is used 2 stated that the do and that she (ASM). During an interview concern was share administrator. The following facility "CLINICAL RECORUNDE and interview concern was share administrator. The following facility "CLINICAL RECORUNDE and interview concern was share administrator. The following facility "CLINICAL RECORUNDE and interview concern was share administrator.	rege 67 vas asked if one could resident's name and room nt's chart. LPN # 4 stated that nt the room number and bed if the other resident. onducted on 8/11/16 at 7:55 ministrative staff member) # 2, es, ASM #2 was shown the copy of the clinical record another resident's name and esident # 9's chart. ASM # 2 should not have referred to the resident's chart. Not even hould be identified." When d for a copy of the facility ated there was no policy that it actice". When ASM # 2 was as the "best practice" ASM # ocumentation guide is used # 2) would print out a copy. on 8/11/16 at 12:35 p.m. this d with ASM # 1, the cy document was reviewed: RD SYSTEM - OVERVIEW" GUIDELINES: Clinical records each patient that are complete, and systematically organized. record reports the actual ndividual and contains on to validate patient status are providedThe center ion contained in the clinical tial, regardless of the form or the records are expected to adhere	F 5	has been removed ar the appropriate record (8/10/16). The records of all recurrently residing in with DDNR orders haudited by the DON accuracy and comple (8/11/16).	rd sidents the faci	lity	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ' =	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495011	B. WING			C 08/11/2016		
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA				STREET ADDRESS, CITY, STATE, ZIP 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		7071172010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 514	No further documexit. According to Functional Function of the Park of the Par	page 68 es and professional standards" dentation was provided prior to damentals of Nursing Made Lippincott Williams and Wilkins, page 23: "Nursing a highly significant issue since a fundamental feature of ient records are legally valid, ccurate and comprehensive so communicated effectively to the Unless the content of rovides an accurate depiction of rovides an accurate depiction of rovides an accurate that what fail to record can produce an on the care that is provided by f the health care team." ains a quotation on page 477 entation as follows: s anything written or printed that cord or proof for authorized entation within a client medical spect of nursing practice. Intation must be accurate, and flexible enough to retrieve attain continuity of care, track and reflect current standards of indamental Nursing Skills and the dition, Chapter 3, pg. 36 heare setting requires accurate cumentation. The medical documentRecords must be	F 5	All the residents resid facility have the poter affected by this allege deficient practice.	ling in the			

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timely, objective, accurate, complete and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495011	B. WING		1	C 11/2016
	PROVIDER OR SUPPLIER	VICES-ALEXANDRIA	1	STREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	1 00.	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF THE PROPORTION OF THE PROPOR	BE	(X5) COMPLETION DATE
F 514	Continued From p	age 69	F 514	III Systemic Changes		
	durable do not res	led to have Resident #7's suscitate (DDNR) form he resident's resuscitation		The DON or designee will reducate Licensed Nurses on proper procedure of		
	10/30/15 and read diagnoses that inchigh blood pressur disease, difficulty hip. The resident's data set), a quarte (assessment refer resident having a (brief interview for resident was modernake daily decision	the thick that included but were not limited to: so pressure, chronic obstructive lung to, difficulty walking, anxiety and fractured to resident's most recent MDS (minimum t), a quarterly assessment with an ARD tement reference date) of 5/8/16 coded the to having a nine out of 15 on the BIMS terview for mental status) indicating the to twas moderately impaired cognitively to aily decisions. Resident #7 was coded as the try impaired cognitively to aily decisions. Resident #7 was coded as the try impaired cognitively to aily decisions that included but were not limited to: DDNR orders and DDNR forms, and accurate filing of residents' information.				
	form signed and diphysician and respondent polysician and respondent polysician and respondent polysician and respondent polysician and polysician and polysician pol	nt #7's clinical record revealed a dated on 11/2/15 by the ponsible party titled, "Durable te Order! further certify (must The patient is CAPABLE of ed decision about providing, thdrawing a specific medical se of medical treatment ent is required). 2. The patient is aking an informed decision withholding, or withdrawing a reatment or course of medical e he/she is unable to ature, extend or probable the proposed medical decision,				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		P) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495011	B. WING			1	C 11/2016	
	MANORCARE HEALTH SERVICES-ALEXANDRIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			Trad to	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 514	or to make a ration benefits of alternativas a check box in boxes were blank. Review of the physicated on 11/18/15 DO NOT RESUSCAN interview was cam, with LPN (lice nurse caring for Rethe DDNR form was a do not resuscitate form was completed asked what staff dicompleted, LPN # and ask, and if the POA (power of atto An interview was cam, with ASM (addithe administrator an ursing regarding fresident's DDNR for stated, "Call the do ASM #1 and ASM findings at that times."	nal evaluation of the risks and tives to that decision." There next to each statement, both sician's orders signed and documented, "PATIENT IS A CITATE." conducted on 8/10/16 at 10:57 ensed practical nurse) #5, the esident #7. When asked what as, LPN #5 stated, "This form is the form." When asked if the e, LPN #5 stated, "No." When id if the form was not 5 stated, "I'd go to the patient ey can't (answer) I'd call the orney)." conducted on 8/11/16 at 11:45 lministrative staff member) #1, and ASM #2, the director of the process staff follow if a form is not complete. ASM #1 octor right away and verify it." #2 were made aware of the	F 5	14	IV Monitoring The Medical Records Clerk designee will audit residents clinical records for accuracy and completeness weekly for four weeks and monthly for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for furth audits and/or action plans.	s' or		
		failed to complete the "Durable e Order" (DDNR) for Resident	A proprietation and the state of the state o					
	Resident # 10 was	admitted to the facility on						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495011	B. WING		08	/11/2016	
MANORCARE HEALTH SERVICES-ALEXANDRIA				STREET ADDRESS, CITY, STATE, ZIP O 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		00/11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 514	limited to: hyperten Parkinson's diseas depression. Resident # 10's mode (minimum data set) an ARD (assessme coded Resident # 1 interview for menta - 15, 14- being cogdecisions. Resider limited assistance of activities of daily live. The POS (physician 10 dated "August 2 physician on 7/21/1 Do Not Resuscitate. Review of Resident # Resuscitate) [(NO of clinical record reverses and signed by (Resident # Resuscitate Order and signed by (Resident # 12:38 conducted with LPN regarding the "Dura (DDNR)" sheet for how she identifies to LPN # 1 stated, "I con the binder of the	pses that included but were not sion (1), thyroid disorder (2), e (3), low iron, arthritis and est recent comprehensive MDS (2), an annual assessment with ent reference date) of 6/19/16, 10 as scoring a 14 on the brief of listatus (BIMS), of a score of 0 entively intact for making daily ent # 10 was coded as requiring of one staff member for ing. In order sheet) for Resident # 016" and signed by the 6 documented, "Code Status: e." It # 10's clinical record revealed er that documented, "Resident 10). Resident is DNR (Do Not CPR)]." Further review of the aled a "Durable Do Not (DDNR)" sheet dated 6/20/14 endent # 10) and the physician. The DDNR revealed it to be 15 p.m. an interview was N (licensed practical nurse) # 1 able Do Not Resuscitate Order Resident # 10. When asked the code status of a resident sheck the chart. The color strip is clinical record, green is full	F 5	V Date of Compli 9/16/2016	ance		
		IR, check the physician order eet; they're the same color as					

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CENTERS FOR MEDICARE & MEDIC	5	SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE	PLETED	
		495011	B. WING			1/2016	
	PROVIDER OR SUPPLIER	VICES-ALEXANDRIA	15	REET ADDRESS, CITY, STATE, ZIP CODE 10 COLLINGWOOD ROAD LEXANDRIA, VA 22308		1 00/11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 514	Continued From p	age 72	F 514				
	the DDNR form an signed. LPN # 1 v DDNR form dated After review the fo	nder. The DNR residents have nd it need to be completed and was then asked to review the 6/20/14 for Resident # 10. Impure LPN # 1 acknowledged that ated 6/20/14 for Resident # 10				,	
-	for Clinical Record in the Clinical Rec Written informatio concerning the rig and to formulate a	y "Requirements and Guidelines d Content" documented, "Forms ord: Advance Directives. In is provided to the patient that to accept or refuse treatment an advance directiveA copy of nice directive is maintained in					
	member) # 1, the	D p.m. ASM (administrative staff administrator, and ASM # 2, the were made aware of the					
	No further informathe survey.	ntion was provided by the end of					
	obtained from the	ssure. This information was website: nih.gov/medlineplus/highbloodp					
	neck, just above y endocrine glands, control the rate of problems include and thyroid cance obtained from the	a butterfly-shaped gland in your our collarbone. It is one of your which make hormones that many activities in your body; hypertension, hypothyriodism r). This information was website: us.gov/thyroiddiseases.html>.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		495011	B. WING		<u> </u>	1	11/2016	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA				STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 514	1	-	F 5	514		-		
	Resident #5 was ac diagnoses of but no cancer, psychosis, dementia, depressi thyroid cancer, and The most recent MI quarterly assessme Reference Date) of coded as severely of make daily life decipossible 15 on the I Mental Status) exar requiring total care extensive assistance sistance for transitions.	Imitted on 6/16/15 with the st limited to dementia, prostate obstructive uropathy, on, high blood pressure, tube feeding. DS (Minimum Data Set) was a nt with an ARD (Assessment 7/30/16. Resident #5 was cognitively impaired in ability to sions, scoring a 4 out of a BIMS (Brief Interview for m. Resident #5 was coded as for bathing and eating; e for hygiene; limited fers; supervision for incontinent of bowel, and as		Transport Additional Control of the				
	A review of the clini second page of a 2 physician regarding On 8/11/16 at approte the unit manager fo does the filing in the and that the misfilin	cal record revealed the page document from a						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED		
		495011	B. WING			C 08/11/2016		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> U8/</u>	11/2016	
MANOR	MANORCARE HEALTH SERVICES-ALEXANDRIA				1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF T	BE	(X5) COMPLETION DATE	
F 514	On 8/11/16 at approach Administrator and Daware of the finding provided by the end On 8/10/16 at 5:50 Director of Nursing, #2 and RN #3) were	oximately 12:30 p.m., the Director of Nursing were made gs. No further information was	F	514				

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