

April 1, 2015

Ms. Wietske G. Weigel-Delano, LTC Supervisor Office of Licensure and Certification Division of Long Term Care Services Virginia Department of Health 9960 Mayland Drive, Suite 401 Richmond, Virginia 23233

Dear Ms. Weigel-Delano:

Attached please find the Plan of Correction for HCR-ManorCare Richmond on the corrected copy of the form CMS 2567, related to the standard survey completed on March 4, 2015. As noted in the Plan of Correction, the facility's date of alleged compliance is April 18, 2015.

Please contact me if you have any further questions or concerns.

Thanks.

Sincerely,

Elizabeth Nugent, LNHA

Administrator



#### COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP State Health Commissioner

#### Office of Licensure and Certification

TYY 7-1-1 OR 1-800-828-1120

9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1485 FAX: (804) 527-4502

March 31, 2015

Ms. Elizabeth Nugent, Administrator Manorcare Health Services-Stratford Hall 2125 Hilliard Road Richmond, VA 23228-4600

Dear Ms. Nugent:

RE:

Manorcare Health Services-Stratford Hall

Provider Number 495045

Enclosed is a corrected copy of the form CMS 2567 for the standard survey ending March 4, 2015. A correction has been made to citation F280 based on statement, as we discussed. Please submit the Plan of Correction on the corrected survey report.

The letter, dated 3/18/2015, that accompanied the original survey report is still applicable. If you have any questions about this letter, please feel free to contact me at 804/367-2100. Thank you.

Sincerely,

Wietske G Weigel-Delano, Supervisor

Division of Long Term Care

Enclosure

(804) 367-2126

PRINTED: 03/31/2015 FORM APPROVED OMB NO. 0938-0301

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULT           | riple construction<br>ng  | (X3) DATE SURVE<br>COMPLETED   |
|--------------------------|--|--|---------------------|---|--|
|                          |  | 495045   | B. WING             |   | 03/04/204  |
|                          | PROVIDER OR SUPPLIER  CARE HEALTH SERVI  | CES-STRATFORD HALL REVIS   | SED                 | STREET ADDRESS, CITY, STATE, ZIP CO<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228   | 03/04/2019<br>DE   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY)   | HOULD BE COMPLE PROPRIATE DATE   |
| SS=D                     | survey was conducted. Corrections are requirements. The It survey/report will follow the consisted of 23 curres (Residents #1 throug #28) and five closed #22 through #26). 483.10(c)(6) CONVE FUNDS UPON DEAT Upon the death of a redeposited with the facility staff intervised clinical record revised action and clinical record revised within 30 days after death the survey sample, Resident # 22 expired | edicare/Medicaid standard ed 03/3/15 through 03/4/15. sired for compliance with 42 al Long Term Care Life Safety Code ow.  94 certified bed facility was a survey. The survey sample ent resident reviews th 21, Residents #27 and record reviews (Residents  YANCE OF PERSONAL  "H  resident with a personal fund cility, the facility must convey sident's funds, and a final ands, to the individual or dministering the resident's  is not met as evidenced ew, facility document review iew, it was determined that to convey resident funds eath for one of 28 residents Resident #22.  at the facility on 12/18/14; count was still open on | F 160               | admission to and do no constitute an agreement the alleged deficiencies herein.  To remain in compliance all federal and state regulate center has taken or with actions set forth in the following plan of correct The following plan of constitutes the center's allegation of compliance | ot an t t t with cited  e with ulations, will take he stion. correction e. All d have I by the  facility with a facility, days the inting of probate ident's |

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 these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

|                          |   | A WILLIAM OF VAIOE   |                     |   | <u>/MB NO</u> . 0938-039   |
|--------------------------|---|--|---------------------|---|--|
| STATEME<br>AND PLAN      | NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED  |
|                          |   | 495045   | B. WING             |   | 03/04/2015   |
|                          | PROVIDER OR SUPPLIER<br>RCARE HEALTH SER  | R<br>VICES-STRATFORD HALL REVIS  | SED 2               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228   | 1 03/04/2015   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DÉFICIENC   | TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | DE COMPLETION  |
|                          | The findings included Resident # 22 was 3/20/09 and readmediagnoses that incoronary artery dis Alzheimer's diseas schizophrenia, and The most recent Massessment, a sign with an assessment coded Resident # 20 others and as rarel understood. Resident graverely cogging severely cogging severely cogging severely cogging an interview OSM (other staff meoffice manager, it was 22 still had an open balance of \$1,191.6 did not realize that (resident fund account fund account to be closed policy was made at 10 of "NDC" (National E | de:  admitted to the facility on nitted on 7/22/14 with luded but were not limited to: lease, diabetes, arthritis, lee, anxiety, hyperlipidemia, it depression.  IDS (minimum data set) nificant change assessment, not reference date of 10/14/14, 22 as rarely understands by able to make herself lent # 22 was also coded as nitively impaired for daily resident # 22 expired at the limit or the conveyance of the limit of the conveyance of the limit o | F 160               | All residents with personal funds deposited with the facility have the potential to be affected.  Audit completed on all residents with personal funds to ensure funds were conveyed within 30days of discharge.  Criteria 3  Business Office staff have been reeducated on resident personal fund accounts.  Criteria 4  Administrator/designee will audit all residents with personal funds to ensure funds were conveyed within 30 days discharge weekly x4 weeks and mon x2 months and report to QAA recommendations.  Criteria 5  The facilities alleged date of complia April 18, 2015. | ine to the state of the state o |

|  |  |   |  |   | TE SURVEY<br>MPLETED                          |                            |   |
|--|--|---|--|---|---|----------------------------|---|
|  |  | 495045  | B. WING_   |   | 03  | //04/2015                  |   |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | ICES-STRATFORD HALL REVIS  | BED .   | STREET ADDRESS, CITY, STATE, ZIP C<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |   |   | _                          |   |
| PREFIX                                       | (EACH DEFICIENC)   | MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | SHOULD BE                                     | (X5)<br>COMPLETION<br>DATE | _ |
| F 160  | begin the process of "Status Change For faxed."  On 3/4/15 at 3:10 profession of what the facility upon to resident fund according guide that is this guide was printed for this guide the for "Resident Expires: be faxed to NDC impresident's death so after the date of exposurceThe account receives the Status to close the account closed immediately in the status of the status to close the account closed immediately in the status of | inf closing the account. The firm" was the item that was some account. The firm" was the item that was seen to guide them in regards counts. Identifying the magement System" as the used; a copy of a portion of ed and presented. On page # following was documented: A Status Change form should mediately following the that direct deposits received in the will remain open until NDC Change form instructing them in the account should be unless waiting for Social | F 16   |   |   |                            |   |
| SS=D   | 483.13(c) DEVELOR ABUSE/NEGLECT, The facility must devipolicies and procedumistreatment, neglecand misappropriation This REQUIREMENT by: Based on staff interview, and employed etermined that the formal procedure in the staff interview.  | P/IMPLMENT ETC POLICIES  relop and implement written ires that prohibit et, and abuse of residents n of resident property.  F is not met as evidenced riew, facility document e record review, it was   | F 220  | It is the intended practice of the develop and implement written and procedures that prohibit magnet, and abuse of resident misappropriation of resident procedures.  Criteria 1  CNA #3's employee reference checked and placed into her effile. | en policies mistreat, s and property. es were | 04/18/15                   |   |

| STATEMENT<br>AND PLAN (               | FOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---------------------------------------|---|---|--|---|-------------------------------|----------------------------|
|                                       |   | 495045  | B. WING                                |   | 02/0                          | 45504.6                    |
|                                       | PROVIDER OR SUPPLIER<br>CARE HEALTH SERV  | ICES-STRATFORD HALL REVIS   | SED 2                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228   | 1 03/0                        | <u>4/2015</u>              |
| (X4) ID<br>PREFIX<br>TAG              | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTIX<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | DBE                           | (X5)<br>COMPLETION<br>DATE |
| F 226                                 | reviewed.  The facility was una<br>employee reference<br>facility abuse policy  | ige 3 (3) of five employee records (3) of five employee records (able to provide evidence that (as were obtained per the (a), for CNA (certified nursing (a) was newly hired employees. | F 226                                  | All employee files have the potential affected.  All current employee files were checked for reference checks on file.  Criteria 3  HR staff have been reeducated on  | ked                           |                            |
| i i i i i i i i i i i i i i i i i i i | four months were re- Review of CNA #3's that CNA #3 was hir Further review of CN failed to evidence th completed prior to th During an Interview a 2:25 p.m. with OSM Director of Human R asked whether or no were completed at th DSM #6 stated that a ecord where that was to describe the verificatives prior to the hire When we receive the et up for an interview of hire the applicant of pre-employment ap complete the sworn s onsent to complete the references are re- | rds of new hires for the last equested and reviewed.  employee record revealed ed as a CNA on 12/29/14.  NA #3's employee record at employee references were                            |  | checking references for all new hire to hire date and have been reeducate facility abuse policies.  Criteria 4  Administrator/designee will audit all hire employee files weekly x4 weeks monthly x2 months and report to QA recommendations.  Criteria 5  The facilities alleged date of complia April 18, 2015. | new<br>and<br>A               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | TIPLE CONSTRUCTION<br>ING | (X3) DATE SURVEY<br>COMPLETED  |                 |  |
|--|--|--|---------------------------|--|-----------------|--|
|  |  | 495045   | B. WING                   |  | 03/04/2015      |  |
|  | PROVIDER OR SUPPLIER   | CES-STRATFORD HALL REVIS   | SED                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228                                    |                 |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFID<br>TAG       | PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES (DEFICIENCY)       | DIBE COMPLÉTION |  |
| F 226  | consent form." OSI not this was done for am sure we did it, we in her record. I can't he facility's policy Prospective Employ Statement. It is (facility evaluate references Procedures. 4. Referenducted before act The Administrator at made aware of the fapproximately 10:30 | M #6 was asked whether or or CNA #3, OSM #6 stated, "I be just failed to document this it find it."  (Reference Requests for rees" documented, "Policy ility name) policy to obtain and for all potential employees, rence checks are to be extual employment begins."  and Director of Nursing were indings on 3/4/15 at a.m. | F 2:                      | 26   |                 |  |
| F 278<br>SS=E  | 483.20(g) - (j) ASSE<br>ACCURACY/COOR  | on was provided prior to exit. SSMENT DINATION/CERTIFIED st accurately reflect the   | F 27                      | It is the intended practice of this facil have an assessment that accurately re                                      |                 |  |
|  | each assessment wit<br>participation of health<br>A registered nurse m   | n professionals.  ust sign and certify that the  |                           | the resident's status.  Criteria 1  Resident # 5's MDS was reviewed at corrected.  Resident #7's MDS was reviewed an | 1               |  |
|  |  | completes a portion of the in and certify the accuracy of  |                           | Resident #10's MDS was reviewed an corrected.  |                 |  |
| Ì  | Willfully and knowingly<br>false statement in a n  | Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than   |                           | Resident #14's MDS was reviewed a corrected.   | ba              |  |

| į |                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULT           | PLE CONSTRUCTION  |   | <del>O. U930-U39</del><br>ATE SURVEY |
|---|--------------------------|---|--|---------------------|---|---|--------------------------------------|
|   | THE PERMIT               | OF CORRECTION   | IDENTIFICATION NUMBER:   | A. BUILDING         |   |   | OMPLETED                             |
|   |                          |   | 495045   | B. WING _           |   |   | 3/04/2015                            |
|   |                          |   | CES-STRATFORD HALL REVIS   | ED                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228   |   | 3/0-4/20 13                          |
|   | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>BC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)   | 心心 食管   | (X5)<br>COMPLETION<br>DATE           |
|   | 3 ( ) C   F   3 ( ) d    | \$1,000 for each ass willfully and knowing to certify a material a resident assessment penalty of not more assessment.  Clinical disagreemer material and false store and clinical record reto ensure a complete (minimum data set) a residents in the surversidents in the surversidents in the surversidents in the surversident and the resident ascurrently being treated Diagnoses on the signassessment, with an Alate) of 12/29/14 and assessment with an Alate of 12/29/14 and assessment reference the Interpreterences had been assessment assessment reference.  Resident #7's annual assessment reference had been assessment assessment reference.  Resident #10's signal minimum Data Set) a id not accurately reflecting the set of the courage of the signal minimum Data Set) a id not accurately reflecting the set of the se | essment; or an individual who ply causes another individual and false statement in a it is subject to a civil money than \$5,000 for each of the total total than the subject to a civil money than \$5,000 for each of the total than th | F 278               | All residents have the potential to affected.  Resident's MDSs will be reviewed quarterly, annual and significant of for coding of Sections I, F, and K.  Criteria 3  IDT team has been re-educated by MDS/designee on accuracy of code the MDS.  Criteria 4  The IDT team will review resident during quarterly, annual and significanting quarterly, annual and significantes MDS for coding related to diagnoses, swallowing/nutritional s and activity residents' interview we x4weeks and monthly x2 months ar report to QAA committee for review recommendations.  Criteria 5  The facilities alleged date of complit April 18, 2015. | I for hange ling on scant active tatus, eakly ad wand |                                      |
|   | 4                        | . Kesident # 14's au:   | erterly MDS (Minimum Data  | ĺ                   |   |   | *                                    |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|---|--|--|-------------------------------|----------------------------|
|                          |  | 495045  | B. WING                                |  | 02                            | 3/04/2015                  |
|                          |  | ICES-STRATFORD HALL REVI  | SED 21                                 | REET ADDRESS, CITY, STATE, ZIP<br>25 HILLIARD ROAD<br>ICHMOND, VA 23228                    | CODE                          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |
|                          | Set) assessment, accurately reflect the accurately reflect the The findings included. In For Resident #5, coded the resident currently being treat Diagnoses on the states assessment, with a date) of 12/29/14 at assessment with ar Resident #5 was act with a recent readmediagnoses that inclusively, skin infection failure to thrive, demonary disease, blood pressure, deel inflammation of the The most recent ME change assessment reference date) of 12 as being moderately cognitive decisions, requiring extensive a member for all of he The MDS assessment with an ARD of 12/13 Section I - Active Diagracture." | dated 10/26/14, did not the Resident's height.  e:  the facility staff incorrectly as having a fracture that was ted in Section I - Active ignificant change MDS in ARD (assessment reference and the quarterly MDS in ARD of 12/17/14.  Imitted to the facility on 9/8/14 dission on 10/18/14 with ided but were not limited to: on, altered mental status, adult nentia, chronic obstructive congestive heart failure, high in vein thrombosis, and | F 278                                  |  |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | TIPLE CONSTRUCTION   |                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|---------------------|--|-----------------------------------|-------------------------------|--|
|  |  | 495045  | B. WING             |  | n2                                | 3/04/2015                     |  |
| AMD PLAN OF CORRECTION  A95045  NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-STRATFORD HALL REV  (X4) ID PREFEX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 278  Continued From page 7  Review of the clinical record did not reveal any documentation regarding another fracture.  An interview was conducted with RN (registered nurse) #1, the MDS coordinator, on 3/4/15 at 9:0 a.m. regarding what other fracture Resident #5 had present. RN #1 stated, "She had a lumbar vertebrae fracture in September 2014." When asked if the resident should be coded for this fracture on the significant change MDS with an ARD of 12/29/14 and the quarterly MDS assessment with an ARD date of 12/17/14. RN #1 stated, "Not if she isn't being treated for it."  An interview was conducted with RN #2, an MDS coordinator, on 3/4/15 at 9:07 a.m. RN #2 was present during the interview with RN #1. RN #2 pulled out her worksheets used for completing both of the MDS assessments for Resident #5 in December 2014. RN #2 stated, "I think it's an error on my part. I even have a note that I was to remove that diagnosis as she was no longer being treated for the lumbar fractures. My mistake."  CMS RAI Manual October 2014: 2. Determine whether diagnoses are active: Once a diagnosis is Identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's plan of care during the 7-day look-back period, as | SED .  | STREET ADDRESS, CITY, STATE, 2125 HILLIARD ROAD RICHMOND, VA 23228  |                     |  |                                   |                               |  |
| PREFIX (EACH   | I DEFICIENC  | Y MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>X (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| Review of document An interview of the present of the pulled out both of the December error on manistrake."  CMS RAI 2. Determine a diagnosis the diagnosis resident's or behavior monitoring look-back have been current state of care dur  | f the clinic tation regime was conting what ent. RN # fracture in the sign 2/29/14 are the was conting the information of the i | cal record did not reveal any arding another fracture.  conducted with RN (registered a coordinator, on 3/4/15 at 9:01 at other fracture Resident #5 1 stated, "She had a lumbar in September 2014." When at should be coded for this ifficant change MDS with an indicant change MDS with an indicated with RN #2, an MDS 15 at 9:07 a.m. RN #2 was interview with RN #1. RN #2 sheets used for completing sessments for Resident #5 in N #2 stated, "I think it's an even have a note that I was to sis as she was no longer a lumbar fractures. My  ctober 2014: are diagnoses are active: Once fied, it must be determined if we. Active diagnoses are active: Once in diagnoses are a direct relationship to the inctional, cognitive, or mood inedical treatments, nursing if death during the 7-day onto include conditions that do not affect the resident's plan | F 2                 | 78   |                                   |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | TIPLE CONSTRUCTION<br>DING |   | (X3) DATE SURVEY<br>COMPLETED          |                            |
|---|--|--|----------------------------|---|--|----------------------------|
|   |  | 495045   | B. WING                    |   | 03                                     | /04/2015                   |
|   | PROVIDER OR SUPPLIER   | ICES-STRATFORD HALL REVI   | SED                        | STREET ADDRESS, CITY, STATE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |  |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DÉFICIÉNC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG         |   | ACTION SHOULD BE<br>TO THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|   | The administrator a made aware of the 11:06 a.m.  2. The facility staff Resident #7's annu (assessment refere demonstrate the Impreferences had be Resident #7 was as 10/20/11 and most with diagnoses that to: osteoporosis, president #7's most set), a quarterly ass (assessment refere the resident's cognimpaired.  Section B0700 of Ran ARD of 12/16/14 understood and as Section F0300 doct Daily and Activity President of the complete or significant other. rarely/never understoother not available Daily and Activity President with RN (MDS coordinator. Fidepartment was resident was resident of the coordinator. Fidepartment was resident was resident as a made a conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment was resident and conducted with RN (MDS coordinator. Fidepartment and conducted | and director of nursing were above findings on 3/4/15 at failed to accurately code all MDS with an ARD ence date) of 12/16/14 to terview for Daily and Activity een attempted.  Idmitted to the facility on recently readmitted on 2/11/15 tincluded but were not limited neumonia and glaucoma. Trecent MDS (minimum data sessment with an ARD ence date) of 2/18/15, coded tion as being severely esident #7's annual MDS with coded the resident as being understanding verbal content.  Immented, "Should Interview for references be Conducted? - vali residents able to sident is unable to complete, interview with family member |                            | 278   |  |                            |

| - ,, ,   | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII | IPLE CONSTRUCTION NG   | TION (X3) DAT COM |                            |
|--|--|---|-------------------------|--|-------------------|----------------------------|
|  |  | 495045  | B. WING_                |  | 0                 | 3/04/2015                  |
| NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-STRATFORD HALL REVISED |  |   | ED                      | STREET ADDRESS, CITY, STATE, ZIP COE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228                   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE          | (X5)<br>COMPLETION<br>DATE |
|  | staff talks to the rescomplete the staff a asked how staff det interviewable and if on any other section RN #1 stated, "Sect sometimes understainterview."  On 3/4/15 at 10:20 acconducted with OSM activities director. Of determines if a residuated, "If they are froutines and give sewas asked if Reside OSM #5 stated, "Ye not be able to tell you interviewable for preshown Resident #7's assessment and asl Dally and Activity Pro OSM #5 stated she Resident #7 but if the resident doesn't the staff assessment F0300 of Resident #6 coded. OSM #5 stated stated of the coded. OSM #5 stated staff assessment F0300 of Resident #6 coded. OSM #5 stated staff assessment F0300 of Resident #6 coded. OSM #5 stated staff coded. | ident and if not then they issessment. RN #1 was ermines if a resident is this determination was based in of the MDS assessment. Iden B. If they are usually or bod, they can attempt the a.m., an interview was a.m., an interview able. OSM #5 was asked how she dent is interviewable. OSM #5 amiliar with their activities and ansible answers." OSM #5 and #5 was interviewable. She is confused and may be undereasted the interview for efferences was not attempted. Attempted the interview with ere are three questions that answer then she completes at. OSM #5 was asked how it is 12/16/14 MDS was ted, "0. That's not true. It's | F 27                    | 78   |                   |                            |
|  | stated she refers to a Medicare & Medicare & Medicare & Medicare Assessment Instrum completing MDS ass   |   |                         | į  |                   |                            |
| }  | The CMS RAI manu   | al documents the following:   |                         |  |                   |                            |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                   | IPLE CONSTRUCTION<br>IG   |                              | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|---|------------------------------|-------------------------------|--|
|                          |  | 495045  | B. WING _           |   | 02                           | 3/04/2015                     |  |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI  | CES-STRATFORD HALL REVIS  | ED                  | STREET ADDRESS, CITY, STATE, ZIP<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228              |                              |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SCIDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
|                          | Intent: The intent of obtain information r preferences for his activities. This is be information is obtain or through family or interviews if the resipreferences. The ininterview is just a polymer of the ininterview. For all-inclusive. For an individual interpreter of the ininterview of the initerview of the initerview. Skip to Formatter of the interview of the int | FERENCES FOR ITINE AND ACTIVITIES Items in this section is to egarding the resident's or her daily routine and st accomplished when the ned directly from the resident significant other, or staff ident cannot report formation obtained during this ortion of the assessment. uld use this as a guide to ized plan based on the es, and is not meant to be view for Daily and Activity inducted?  resident preference interview I. the interview should not be esident. This option should be its who are rarely/never ed an interpreter but one was no do not have a family int other available for 800, (Staff Assessment of eferences). Isident interview should be on should be selected for is not needed or is present, in member or significant other in Continue to F0400 irreferences) and F0500 | F 27                | 8   |                              |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--|--|-----------------------------------|-------------------------------|--|
|   |  | 495045   | B. WING                                |  | 0                                 | 3/04/2015                     |  |
|   | PROVIDER OR SUPPLIER   | CICES-STRATFORD HALL REVIS   | ED                                     | STREET ADDRESS, CITY, STATE, 2<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 | ZIP CODE                          |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>LY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    |  | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 278   | Continued From p   | age 11   | F 2                                    | 78   |                                   |                               |  |
|   | (Minimum Data Sedid not accurately Resident #10 was 7/23/09 and again included: anemia (hypertension (high mellitus (high bloocholesterol), anxie asthma (disease the mental status, kidr Resident # 10's me (minimum data set assessment, with a (ARD) of 3/25/14, 14 on the brief interesident was a cassistance of one daily living. In Sect Status, under K020 Resident # 10 was During a clinical remost recent cosignificant change 3/25/14. The most assessment with a comparing Section Status, under K020 Resident # 10 was During an interview | significant change MDS et) assessment, dated 3/25/14, reflect the Resident's height.  admitted to the facility on on 5/31/14 with diagnoses that (low iron), heart failure, blood pressure), diabetes d sugar), hyperlipidemia (high tty, depression, schizophrenia, hat affects breathing), altered ney disease, obesity and pain.  ost recent comprehensive MDS t) a significant change an assessment reference date coded the resident as scoring a erview for mental status (BIMS) 5, 15 being cognitively intact, coded as requiring extensive staff member for all activities of iton K: Swallowing/Nutritional 00: Height and Weight, coded as being 64 inches tall.  cord review the most current essessment was compared to emprehensive MDS, a assessment with an ARD of t recent MDS was a quarterly in ARD of 12/15/14. When K: Swallowing/Nutritional 00: Height and Weight, coded as being 62 inches tall. |  |  |                                   |                               |  |
|   |  | v on 3/4/15 at approximately<br>(registered nurse) #2, the MDS   |  |  |                                   |                               |  |

| STATEMENT OF DEFICIE<br>AND PLAN OF CORRECT   |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                          | (X2) MU<br>A. BUILI |     | E CONSTRUCTION   |      | TE SURVEY<br>MPLETED       |
|---|---|--|---------------------|-----|--|------|----------------------------|
|   |   | 495045   | B. WING             |     |  | 03   | 3/04/2015                  |
| NAME OF PROVIDER OF MANORCARE HEA   |   | ICES-STRATFORD HALL REVIS  | ED                  | 21  | REET ADDRESS, CITY, STATE, ZIP CODE<br>125 HILLIARD ROAD<br>ICHMOND, VA 23228                                |      |                            |
| PREFIX (EACH  | DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG   |     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | (X5)<br>COMPLETION<br>DATE |
| coordinate Resident the resident the resident the resident supervised procedure stated, "If measured stand we to finger theight is and if real review Recomprehe assessme (ARD) of assessme asked who Resident #3 stated, "On 3/4/15 approximanursing) recomposed by the coding for inches, the re-measure the DON sections of the coding for inches, the re-measure the DON sections of the coding for inches, the re-measure the DON sections of the coding for inches, the re-measure the DON sections of the coding for inches, the re-measure the DON sections of the coding for inches, | #10, RN factors height at ly 2:50 an interval at ly 2:50 ar. When a for obtain the resided from heasured dmitted." He asident #10 an interval at ly 3:20 asked to the DS assest date ARD assest at ly 3:20 assest | ing the inconsistent height for<br>#2 stated, "The nurses input                | F                   | 278 |  |      |                            |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1                  |      | CONSTRUCTION  |           | ATË SURVEY<br>DMPLETED     |
|--------------------------|--|--|--------------------|------|---|-----------|----------------------------|
|                          |  | 495045   | B. WING            |      |   | 0:        | 3/04/2015                  |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI  | CES-STRATFORD HALL REVIS   | €D                 | 2125 | EET ADDRESS, CITY, STATE, ZIP C<br>3 HILLIARD ROAD<br>HMOND, VA 23228                         |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFO<br>TAG | ĸ    | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
|                          | not been re-measure 2011.  Review of the facilit Height and Weight height on admission measured not estimate the findings on 3/4/1 No further information.  The Administrator at the findings on 3/4/1 No further information.  4. Resident # 14's of Set) assessment, data accurately reflect the Resident #14 was an alled the control of the control of the set of the resident # 14's most (minimum data set) an assessment refer coded the resident at interview for mental of the resident was coded assistance of one standally living. In Section Status, under K0200 Resident # 14 was coded the resi | y policy "System for Obtaining documented in part, "Obtain and yearly. Height is actually ated."  Ind DON were made aware of 5 at approximately 4:30 p.m. on was provided prior to exit. Quarterly MDS (Minimum Data ated 10/26/14, did not a Resident's height.  Idmitted to the facility on a 1/16/14 with diagnoses that w iron), heart failure, lood pressure), renal disease), diabetes meliitus hyroid disorder, cardiac amputation.  It recent comprehensive MDS an annual assessment, with ence date (ARD) of 1/24/15, as scoring a 15 on the brief status (BIMS) of a score of 0 organitively intact. The as requiring extensive aff member for all activities of a K: Swallowing/Nutritional: Height and Weight, oded as being 70 inches tall. | F 2                | 78   |   |           |                            |
|                          | MDS a quarterly asse   | essment was compared to  |                    | 1    |   |           | 1                          |

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>(DENTIFICATION NUMBER:   | , ,                | TIPLE CONSTRUCTION   | O                               | X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|---|--------------------|--|---------------------------------|------------------------------|
|                          |   | 495045  | B. WING            |  |                                 | 03/04/2015                   |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI   | CES-STRATFORD HALL REVIS  | ED                 | STREET ADDRESS, CITY, STATE, Z<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 | IP CODE                         |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | TION SHOULD BI<br>THE APPROPRIA |                              |
| F 278                    | the most recent corrassessment with arrecent MDS was a ARD of 10/26/14. A Swallowing/Nutrition Height and Weight, being 72 inches tall During an interview 2:45 p.m. with RN (coordinator, regardi Resident #14, RN # the resident's height On 3/4/15 an interviapproximately 2:50 supervisor. When a procedure for obtain stated, "If the reside measured from hea stand we measure to finger tip." When height is measured, and if readmitted." review Resident #14 comprehensive ann ARD of 1/24/15 and assessment with the asked why there wa #14's heights from 7 "I don't think there is On 3/4/15 an interviapproximately 3:20 nursing) regarding FON was asked to a documented on the assessment, with an | nprehensive MDS, an annual ARD of 1/24/15. The most quarterly assessment with an When comparing Section K: nal Status, under K0200: Resident # 14 was coded as on 3/4/15 at approximately registered nurse) #2, the MDS ng the inconsistent height for 2 stated, "The nurses input t."  ew was conducted at p.m. with RN # 3, the nursing asked to describe the ning a resident's height, RN #3 ant is able to stand they are d to toe. If they are unable to heir arm span from finger tip asked how often a resident's RN #3 stated, "On admission RN #3 was then asked to I's heights documented on the ual MDS assessment, with an the quarterly MDS a ARD of 10/26/14. When is a discrepancy of Resident I'z to 70 inches, RN #3 stated, | F 2                | 78   |                                 |                              |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION<br>IG  |            | TE SURVEY<br>MPLETED        |
|--------------------------|--|---|---------------------|--|------------|-----------------------------|
|                          |  | 495045  | B. WING             | ,  | 03         | /04/2015                    |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SER\   | CICES-STRATFORD HALL REVIS  | ED                  | STREET ADDRESS, CITY, STATE, ZIP COL<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228                                   |            |                             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SH<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE   | (X\$)<br>COMPLETION<br>DATE |
|                          | 10/26/14. When a discrepancy of Rei 70 inches the DON we re-measured a why there was a diheight the DON state Review of the facility and Weight height on admission measured not estimate the findings on 3/4. No further informate 483.20(d), 483.20(COMPREHENSIVI A facility must use to develop, review comprehensive plant for each reside objectives and time medical, nursing, a needs that are idented to be furnished to a highest practicable psychosocial well-b §483.25; and any serequired under §due to the resident. | sked why there was a sident #14's heights from 72 to it stated, "In November 2014 If the residents." When asked screpancy in Resident #14's ated, "People shrink over time." ity policy "System for Obtaining "documented in part, "Obtain on and yearly. Height is actually mated."  and DON were made aware of /15 at approximately 4:30 p.m. ition was provided prior to exit. k)(1) DEVELOP E CARE PLANS  the results of the assessment and revise the resident's | F 27                |  | resident's | 04/18/15                    |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRUCTION<br>NG   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|---------------------|--|-------------------------------|--|
|                          |  | . 495045   | B. WING             | 1  | 03/04/2015                    |  |
| 1                        | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI  | CES-STRATFORD HALL. REVIS  | ED                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION ( EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF TH | D BE COMPLÉTION               |  |
| F 279                    | under §483.10(b)(4   | _  | F 27                | All residents have the potential to be affected.   |                               |  |
|                          | by: Based on staff inter<br>review, the facility si<br>plan for one of 28 re<br>Resident #5.                             | rview and clinical record<br>taff failed to develop a care<br>esidents in the survey sample,   |                     | CAAs will be reviewed to ensure the plans are initiated for all triggered a  Criteria 3  IDT team has been reeducated by MDS/designee on initiation of reside care plans based on triggered areas of   | reas.                         |  |
|                          | address cognitive to<br>triggered on the CA<br>the significant chang<br>assessment, with ar<br>date) of 12/29/14, for    |  |                     | CAAs.  Criteria 4  The ADNS/designee will randomly resident's care plans based on trigge areas on CAAs weekly x4 weeks an  | audit<br>red<br>d             |  |
|                          | with a recent readmit<br>diagnoses that inclu-<br>anxiety, skin infectio<br>failure to thrive, dem<br>pulmonary disease, | mitted to the facility on 9/8/14 ission on 10/18/14 with ded but were not limited to: n, altered mental status, adult tentia, chronic obstructive congestive heart failure, high p vein thrombosis, and            |                     | monthly x2 months and report to QA committee for review and recommendations.  Criteria 5 The facilities alleged date of complications, 2015.   |                               |  |
| ·                        | significant change as<br>(assessment referent<br>coded Resident #5 a<br>to make daily cogniti<br>was coded as requiri    | S (Minimum Data Set) was a seesment, with an ARD seesment, with an ARD see date) of 12/29/14, and seeing moderately impaired we decisions. The residenting extensive assistance of rall of her activities of daily |                     |  | ,                             |  |
|                          |  | rea Assessment Summary, ange assessment, with an   |                     |  |                               |  |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1, ,               | TIPLE CONSTRUCTION<br>NNG   |   | TE SURVEY<br>MPLETED       |
|--------------------------|--|---|--------------------|---|---|----------------------------|
|                          |  | 495045  | B. WING            |   | oː  | 3/04/2015                  |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERV   | ICES-STRATFORD HALL REVIS   | ED                 | STREET ADDRESS, CITY, S<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 | TATE, ZIP CODE  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE, PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | X (EACH CORRECT<br>CROSS-REFERENC                                   | LAN OF CORRECTION<br>TVE ACTION SHOULD BE<br>ED TO THE APPROPRIATE<br>FICIENCY) | (X5)<br>COMPLETION<br>DATE |
| F 279                    | ARD (assessment the resident was clarea Triggered" for column, "Care Plan checked with an "X area was to be can Review of the com 10/20/14, and revie a care plan to addr loss/dementia.  An interview was conurse) #1, the MDS a.m. RN #1 was ascare plan and locat cognition or dementian. She then states who is responsection of the MDS | reference date) of 12/29/14, hecked under column, "Care recognitive loss/dementia. The ning Decision" was also C," indicating that the triggered e planned for this resident.  prehensive care plan dated, ewed on 1/12/15, did not reveal ress the resident's cognitive coordinator, on 3/4/15 at 9:10 sked to review Resident #5's re on the care plan addressing that RN #1 reviewed the care ted she didn't see it. When onsible for completing the that includes the cognition, a social workers do that | F2                 | 279   |   |                            |
|                          | member (OSM) #7, 9:17 a.m. OSM #7 plan and the signific ARD of 12/29/14 ar plan addresses cog #5. OSM #7 review and stated, "You are asked should cognifor this resident, OS and we checked that it, it should be care The RAI Manual Oc Coding Instructions   | tober 2014:   |                    |   |   |                            |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |              |      | CONSTRUCTION   |     | TE SURVEY                               |
|--------------------------|---|--|--------------|------|--|-----|---|
|                          |   | 495045   | B. WING      |      |  | 0.2 | 3/04/2015                               |
|                          | PROVIDER OR SUPPLIER  | ICES-STRATFORD HALL REVIS  | SED          | 2126 | EET ADDRESS, CITY, STATE, ZIP CODE<br>5 HILLIARD ROAD<br>HMOND, VA 23228                                   |     | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)  | PREFI<br>TAG |      | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | DBE | (X5)<br>COMPLETION<br>DATE              |
| F 279                    | mechanism to dete require review and triggered care area. "Care Area Triggered care and current standar or expert-endorsed resources to conducare area. Docume information regardir Chapter 4 of this mainstructions on the Cand documentation.  For each triggered of Planning Decision" new care plant, care of the current care plant issue(s) identified care area. The "Canmust be completed the RAI, as indicated which is the date that decision(s) were corresident's care plantriggered care area, of the CAA documentation of this manual provides the CAA process, care documentation. | rmine which care areas additional assessment. The sare checked in Column A ad" in the CAAs section. For area, use the CAA process of of practice, evidence-based clinical guidelines and ct further assessment of the nt relevant assessment of the nual provides detailed CAA process, care planning, care area, Column B "Care is checked to indicate that a plan revision, or continuation plan is necessary to address in the assessment of that is e Planning Decision's column within 7 days of completing it by the date in V0200C2, at the care planning in pleted and that the was completed. For each indicate the date and location intation in the "Location and entation" column. Chapter 4 thes detailed instructions on | F2           | 779  |  |     |   |
| F 280                    | made aware of the a<br>11:06 a.m.<br>483.20(d)(3), 483.10   | bove findings on 3/4/15 at   | F 28         | o    |  |     |   |
| 1                        |   | i de la companya de  |              |      |  |     | f                                       |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                  |     | É CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED     |                            |
|--------------------------|--|---|--------------------|-----|--|-----------------------------------|----------------------------|
|                          |  | 495045  | B. WING            |     |  | 03/                               | 04/2015                    |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI  | CES-STRATFORD HALL REVIS  | EĐ                 | 2   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>125 HILLIARD ROAD<br>IICHMOND, VA 23228  |                                   |                            |
| (X4) IÖ<br>PREFİX<br>TAĞ | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRÉCEDED BY FULL<br>SC IDENTIFYING INFORMATION)                       | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)  | 島艦                                | (X5)<br>COMPLETION<br>DATE |
| F 280                    | The resident has the incompetent or other incapacitated under participate in plannich changes in care and A comprehensive cawithin 7 days after the comprehensive assinterdisciplinary team physician, a register for the resident, and disciplines as determined, to the extent put the resident, the resident incapal representative   | e right, unless adjudged<br>orwise found to be<br>the laws of the State, to<br>ng care and treatment or | F 2                | 280 | F280 It is the intended practice of the facili develop a comprehensive care plan w 7 days after the completion of the comprehensive assessment; prepared interdisciplinary team, that includes the attending physician, a RN with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, at the extent practicable, the participation the resident, the resident's family or tresident's legal representative; and periodically reviewed and revised by team of qualified persons after each assessment.  Criteria I  Resident #9 has a revised care plan the address fall prevention. | ithin by an ne ner nd, to n of he | 04/18/15                   |
|                          | by: Based on observatidocument review an was determined that review and revise the for two of 28 resident Residents #9 and #7. The facility staff f. Resident #9's comprefalls on 11/15/14 and 2. The facility staff f. Resident #7's compression #7 | ailed to review and revise<br>rehensive care plan following   |                    |     | Resident #7 has a revised care plan taddress the removal of fall mats.  Criteria 2  All residents have the potential to be affected.  Residents with falls will be reviewed Eagle Room for care plan revisions supdated as appropriate.  Criteria 3  IDT team has been reeducated by MDS/designee on revision of resident care plans.  | in<br>and                         |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

| IDENTIFICATION NUMBER  495045  IDENTIFICATION NUMBER  495046  IDENTIFICATION NUMBER  495045  IDENTIFICATION NUMBER  495046  IDENTIFICATION NUMBER  495045  IDENTIFICATION NUMBER  495045  IDENTIFICATION NUMBER  495046  IDENTIFICATION NUMBER  495047   |            | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULT | TIPLE | CONSTRUCTION  |                    | E SURVEY   |
|--|------------|--|--|-----------|-------|---|--------------------|------------|
| MANORCARE HEALTH SERVICES-STRATFORD HALL REVISED    CAN ID   SUMMARY STATEMENT OF PERCEMPINES   PREPARED PROPERTY TAG   PROPERTION NUTTIES PRECEDED BY FULL REVISED   PREPARED TO THE APPROPRIATE DEPLICATION ORLS DESTRIPTING INFORMATION)   PREPARED TO THE APPROPRIATE DEPLICATION OR SERVICES DESTRIPTING INFORMATION)   PREPARED TO THE APPROPRIATE DEPLICATION OR SERVICES DESTRIPTING INFORMATION)   PREPARED TO THE APPROPRIATE DEPLICATION OF | AND PLAN C | FCORRECTION  | IDENTIFICATION NUMBER:   | 1         |       |   | COM                | PLETED     |
| MANORCARE HEALTH SERVICES-STRATFORD HALL REVISED  SUMMERY SYSTEMENT OF DEFICIENCIES  SUMMERY SYSTEMENT OF DEFICIENCIES  CAND DECEMBER VALUE OF PRECIDENCIES OF THE LEGACIO EXPERIENCY WASTER PRECEDED BY FULL REQUISION VALUE OF PRECEDED TO THE APPROPRIATE DEFICIENCY)  F 280  Continued From page 20  The findings include:  1. Resident #9 was admitted to the facility on 8/28/14 and most recently readmitted on 9/9/14 with diagnoses including, but not limited to: dementia, depression, high blood pressure, psychosis and benign prostate enlargement. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date of 12/17/14, Resident #9 was coded as being severely cognitively impaired for making daily decisions. He was coded as having one fall with no injury and one fall with minor injury during the look-back period.  A review of the nurses' notes for Resident #9 revealed the following note written on 11/15/14 at 1:02 p.m.: "Resident was laid in the bed for a napbecause resident appeared to be sleepy and exhausted. Resident was laid in the bed for a napbecause resident appeared to be sleepy and exhausted. Resident was laid in the bed for a napbecause resident appeared to be sleepy and exhausted. Resident was laid in the bed for a napbecause resident as one stream of the properties of the failway pushing the two exit doors seeking to go out. Resident is a high risk of falling. Resident is a light for the advanced by the properties of the prop |            |  | 495045   | B. WING   |       |   | 03/                | 04/2015    |
| MANORCARE HEALTH SERVICES-STRATFORD HALL REVISED  DAIL D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFOCIENCY MUST are PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION)  FPREFIX TAG  F 280  Continued From page 20 The findings include:  1. Resident #9 was admitted to the facility on 8/28/14 and most recently readmitted on 9/9/14 with diagnoses including, but not limited to: dementia, depression, high blood pressure, psychosis and benign prostate enlargement. On the most recent MDS (milmum data set), a quarterly assessment with assessment reference date of 12/17/14, Resident #9 was coded as being lodepondent for walking, and as requiring the assistance of staff for bed mobility, tolletting, personal hygiere and bathing. He was coded as having one fall with no injury during the lock-back period.  A review of the nurses' notes for Resident #9 revealed the following note written on 11/15/14 at 1:02 p.m.: "Resident was laid in the bed for a nap because resident appeared to be sleepy and exhausted. Resident did not sleep at night. Resident the observed the submany pushing the two exit doors seeking to go out. Resident has a first three abrasions: on the r. (right) forehead, above rt. eyebrow and rt. lower back. Resident as a cut on the lt. (left) eyebrow. [Name of physician] and RIP (responsible party) were made aware. Son said he will take resident to the iname of local hospital]. Neuro (neurological) checks within normal limits, moving all extremities. Resident is condition is stable. No resp. (respiratory) distress. Resident is walking  | NAME OF 6  | PROVIDER OR SUPPLIER   |  | <u> </u>  | ST    | REET ADDRESS, CITY, STATE, ZIP CODE   |                    |            |
| SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY TUIL REGULATORY OR LIST DEPITED IN POPMATION)  F 280  Continued From page 20 The findings include:  1. Resident #9 was admitted to the facility on 8/28/14 and most recently readmitted on 9/9/14 with diagnoses including, but not limited to: demential, depression, high blood pressure, psychosis and benign prostate enlargement. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date of 12/17/14, Resident #9 was coded as being severely cognitively impaired for making daily decisions. He was coded as being severely cognitively impaired for making daily decisions. He was coded as being independent for walking, and as requiring the assistance of staff for bod mobility, tolleting, personal hygiene and bathing. He was coded as having one fall with no injury and one fall with minor injury during the look-back period.  A review of the nurses' notes for Resident #9 revealed the following note written on 11/16/14 at 1:02 p.m.: "Resident was laid in the bed for a nap because resident appeared to be sleepy and exhausted. Resident did not sleep at night. Resident thas difficulty walking, Resident is a high risk of falling. Resident is every difficult to redirect. Resident has a three abrasions: on the rt. (right) forehead, above rt. eyebrow and rt. lower back. Resident as a cut on the lt. (left) eyebrow. [Name of physician] and RIP (responsible party) were made aware. Son said he will take resident to the [name of local hospital]. Neuro (neurological) checks within normal limits, moving all extremities. Resident as condition is stable. No resp. (respiratory) distress. Resident is walking   | MANORO     | ARE HEALTH SERVI   | CES-STRATFORD HALL REVIS   | ED        |       |   |                    |            |
| F 280   Continued From page 20   The findings include:   1. Resident #9 was admitted to the facility on 8/28/14 and most recently readmitted to 19/9/14 with diagnoses including, but not limited to: dementia, depression, high blood pressure, psychosis and benign prostate lenlargement. On the most recentl MDS (minimum data set), a quarterly assessment with assessment reference data of 12/17/14, Resident #9 was coded as being independent for walking, and as requiring the assistance of staff for bod mobility, tolleting, personal hygiene and bathing. He was coded as having one fall with no injury and one fall with minor injury during the look-back period.  A review of the nurses' notes for Resident #9 revealed the following note written on 11/15/14 at 1:02 p.m.: Tresident was laid in the bed for a nap because resident appeared to be sleepy and exhausted. Resident was laid in the bed for a nap because resident appeared to be sleepy and exhausted. Resident did not sleep at night. Resident the addifficulty walking. Resident is a high risk of falling. Resident is very difficult to redirect. Resident has a time abracisms. on the rt. (right) forehead, above rt. eyebrow and rt. lower back. Resident as a cut on the tt. (left) eyebrow. [Name of physician] and RIP (responsible party) were made aware. Son said he will take resident to the (name of local hospital). Neuro (neurological) checks within normal limits, moving all extremities. Resident is condition is stable. No resp. (respiratory) distress. Resident is walking   |            | 014 044 0W CT4   | TENENT OF DESIGNATION  | l         | T     |   |                    | (XS)       |
| The findings include:  1. Resident #9 was admitted to the facility on 8/26/14 and most recently readmitted on 9/6/14 with diagnoses including, but not limited to: dementia, depression, high blood pressure, psychosis and benign prostate enlargement. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date of 12/17/14, Resident #9 was coded as being severely cognitively impaired for making daily decisions. He was coded as being independent for walking, and as requiring the assistance of staff for bed mobility, tolleting, personal hygiene and bathing. He was coded as having one fall with no injury and one fall with minor injury during the look-back period.  A review of the nurses' notes for Resident #9 revealed the following note written on 11/15/14 at 1:02 p.m.: "Resident was alid in the bed for a nap because resident appeared to be sleepy and exhausted. Resident did not sleep at night. Resident is continuously pace (sic) the hallway pushing the two exit doors seeking to go out. Resident has three abrasions: on the rt. (right) forehead, above rt. eyebrow and rt. lower back. Resident also has a cut on the it. (left) eyebrow. [Name of physician] and R/P (responsible party) were made aware. Son said he will take resident to the [name of local hospital]. Neuro (neurological) checks within normal limits, moving all extremities. Resident and oriented) to person. Resident's condition is stable. No resp. (respiratory) distress. Resident is walking  | PREFIX     | (EACH DEFICIENCY   | / MUST BE PRECEDED BY FULL   | PREFIX    | •     | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE   | BE                 | COMPLETION |
| ( 90 (15)(9)   | F 280      | The findings include  1. Resident #9 was 8/26/14 and most rewith diagnoses includementia, depressi psychosis and benithe most recent ME quarterly assessmedate of 12/17/14, R being severely coggidaily decisions. He independent for water assistance of staff if personal hygiene at having one fall with minor injury during  A review of the nurrevealed the following the following the two exit Resident is continue pushing the two exit Resident has difficurisk of falling. Resident also has a [Name of physician were made aware, to the [name of loca (neurological) checall extremities. Resident also here all extremities. Resident also here all extremities. Resident also here all extremities. Resident Reside | es admitted to the facility on ecently readmitted on 9/9/14 uding, but not limited to: on, high blood pressure, gn prostate enlargement. On DS (minimum data set), a ent with assessment reference esident #9 was coded as nitively impaired for making was coded as being liking, and as requiring the for bed mobility, tolleting, and bathing. He was coded as no injury and one fall with the look-back period.  ses' notes for Resident #9 ang note written on 11/15/14 at nt was laid in the bed for a nap ppeared to be sleepy and ent did not sleep at night. Ously pace (sic) the hallway it doors seeking to go out. Alty walking. Resident is a high dent is very difficult to redirect abrasions: on the rt. (right) eyebrow and rt. lower back. It cut on the lt. (left) eyebrow. I and R/P (responsible party) Son said he will take resident alto (alert and oriented) at sondition is stable. No |           | 80    | The ADNS/designee will randomly a resident's care plans related to falls we x4 weeks and monthly x2 months and report to QAA committee for review recommendations.  Criteria 5  The facilities alleged date of compliants | reekly<br>l<br>and |            |

| - 11 1p                  | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ' '               | TIPLE CONSTRUC                             | TION  |           | TE SURVEY                  |
|--------------------------|--|---|-------------------|--|---|-----------|----------------------------|
|                          |  | 495045  | B. WING           | i  |   | 03        | 1/04/2015                  |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERV   | ICES-STRATFORD HALL REVIS   | EĎ                | STREET ADDRE<br>2125 HILLIARD<br>RICHMOND, |   |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | (D<br>PREF<br>TAG | X (EACH                                    | OVIDER'S PLAN OF COI<br>H CORRECTIVE ACTION<br>REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 280                    | A review of the fall revealed that the far the corner of the refloor between the breview revealed that incident as a fall be lying in bed just prict the presence of the corner.  On 3/4/15 at 12:20 nurse) #4 was interstated that Resident "looked like he needs the remembered the Resident #9 into his next time she saw to down the hall as de A review of Emerge instructions for Resident had been place eyebrow.  Further review revealed instruction that had been place eyebrow.  Further review revealed instruction that had been place eyebrow.  Further review revealed instruction that had been place eyebrow.  Further review revealed instruction that had been place eyebrow.  Further review revealed instruction that had been place eyebrow.  Further review revealed instruction that had been place eyebrow.  Further review revealed instruction that had been place eyebrow.  Further review revealed instruction that had been place eyebrow.  Further review revealed instruction that had been place eyebrow.  Further review revealed instruction that had been place eyebrow. | investigation dated 11/15/14 cility staff discovered blood on sident's night stand and on the ed and the nightstand. The it the facility staff treated this cause he had been observed or to the fall, and because of blood on the nightstand p.m., LPN (licensed practical viewed regarding this fall. She it #9 was "very tired" and ded a nap." She stated that lat a staff member assisted the bed. She stated that the he resident; he was walking | F                 |  |   |           |                            |

|                          | TOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 ' '             |      | CONSTRUCTION  |                              | ATE SURVEY<br>OMPLETED     |
|--------------------------|--|--|-------------------|------|---|------------------------------|----------------------------|
|                          |  | 495045   | B, WING           | ·    |   | 0                            | 3/04/2015                  |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERV   | ICES-STRATFORD HALL REVIS  | SED               | 2125 | EET ADDRESS, CITY, STATE, ZIP<br>B HILLIARD ROAD<br>HMOND, VA 23228                       | CODE                         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |      | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 280                    | snack. MD (doctor times with message A review of the con 9/17/14 and most revealed the follow to the 11/15/14 fall: Provide assist to transeded Theraporders. Attempt to restless." A review for the 11/15/14 and the resident's bed vobservation by a stresident had been a prior to both falls. Also revealed theraprior to the falls to sto walk without diffifalls, Resident #9 htherapy services with supervision for ambigurery and the referenced falls.  On 3/4/15 at 12:20 nurse) #4, who was Resident #9 resides the process of updates the stated that every service was the stated that every state of the stated that every service was the stated that every service was stated that every state of the stated that every service was service was service was service was service was serviced to the stated that every service was serviced was | r) is aware. Called RP two e left to call back to facility."  Imprehensive care plan dated ecently updated on 1/22/15 ing interventions for falls prior "Bed in low position ansfer and ambulate as by evaluation and treatment per redirect resident when he is by of the facility investigations de 11/19/14 falls revealed that was in low position on last aff member, and that the cassisted to bed by a CNA just A review of the clinical record py evaluations and treatment estrengthen Resident #9's ability culties. At the time of these had been discharged from ith no recommendations for culation.  of this care plan revealed no reventions following the above  p.m., LPN (licensed practical estrong on the unit where s, was interviewed regarding ating care plans after a fall. eryone is responsible for |                   | 280  |   |                              |                            |
|                          | working at the time<br>the ADON (assistan<br>DON (director of nu<br>documentation rega<br>care plan, LPN #4 s  | lan, including the nurse of the fall, the unit manager, at director of nursing) and the ursing). When shown the arding these two falls and the stated, "I don't know what say why I didn't update the  |                   |      |   |                              |                            |

| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 7 ' '   | TIPLE CO | NSTRUCTION  | (X3) DA'  | TE SURVEY<br>MPLETED       |
|--------------------------|--|---|---------|----------|---|-----------|----------------------------|
|                          | •  | 495045  | B. WING |          |   |           | /04/2015                   |
|                          | PROVIDER OR SUPPLIE<br>CARE HEALTH SER   | R<br>VICES-STRATFORD HALL REVI  | SED     | 2125 H   | tt address, city, state, zip co<br>Hilliard Road<br>Mond, va. 23228                           | OD€       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | PREFO   |          | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE | (XS)<br>COMPLETION<br>DATE |
| F 280                    | care plan. I don't On 3/4/15 at 2:05 member) #2, the ASM #3, the assis (ADON), were into of updating care inthe the charge not the care plan. Sh process of determined the care plans with a staff usually does care plans with a status. ASM #2 si the care plans we the facility's pract meetings at which changes are disc planned. She sta these falls in the there was no doc in the resident's r On 3/4/15 at 3:20 administrator, and these concerns. regarding care plans regarding care plans requested. ASM to updating a care contained in the fa Practice Guide" in "Following review | in p.m., ASM (administrative staff director of nursing (DON), and stant director of nursing erviewed regarding the process plans after a fall. ASM #3 stated urse is responsible for updating the stated that the she was in the mining why these care plans. She stated that the facility a very good job of updating the my changes in a resident's stated that she did not know why are not updated. She described ince of twice-a-day "Eagle Room" in resident incidents/status ussed and interventions are used she remembered discussing Eagle Room, but admitted that umentation of these discussions ecord.  In p.m., ASM #1, the did ASM #2 were informed of Policies and procedures an updates and falls were #2 stated that anything related a plan after a fall would be falls policy.  Incility policy entitled "Falls evealed, in part, the following: of risk factors, environmental |         | 280      |   |           |                            |
|                          | initial care plan is<br>care plan is deve  | clinical conditions, the patient's<br>updated or a comprehensive<br>loped to include individualized<br>ons that focus on the patient's  | ·       |          |   |           |                            |

PRINTED: 03/31/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_\_ B. WING 03/04/2015 495045 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2125 HILLIARD ROAD MANORCARE HEALTH SERVICES-STRATFORD HALL REVISED RICHMOND, VA 23228 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 巾 (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 280 F 280 Continued From page 24 Nothing further was provided prior to exit. Basic Nursing, Essentials for Practice, 6th edition. (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

The facility staff falled to review and revise Resident #7's comprehensive care plan to reflect the removal of fall mats from the resident's room.

Resident #7 was admitted to the facility on 10/20/11 and most recently readmitted on 2/11/15 with diagnoses that included but were not limited to: osteoporosis, pneumonia and glaucoma. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/18/15, coded the resident's cognition as being severely impaired.

Review of Resident #7's clinical record revealed a comprehensive care plan initiated on 1/23/14 and revised on 7/21/14. The care plan documented, "Goal: Minimize risk for falls. Interventions: Bed

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | 1 ' '   | riple construction  | (X3) DATE SURVEY<br>COMPLETED   |  |     |                            |
|--|--|---|---------------------|---|--|-----|----------------------------|
|  |  | 495045  | 8. WING_            |   | _  | 03/ | 04/2015                    |
|  | PROVIDER OR SUPPLIE<br>CARE HEALTH SER   | R<br>EVICES-STRATFORD HALL REVIS  | sed                 | STREET ADDRESS, CITY, ST.<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 | ATE, ZIP CODE  |     |                            |
| (X4) ID<br>PREFIX<br>TAG   | /FACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | ( (EACH CORRECTIVE CROSS-REFERENCE                                    | AN OF CORRECTION<br>REACTION SHOULD<br>TO THE APPROPRICENCY) | BE  | (X6)<br>COMPLETION<br>DATE |
| F 280  | in low position with mats. PDM (perinaised edges aroused in defining perinaised in defining perinaised in definition in definitio | nen occupied. Bilateral floor<br>meter defined mattress [with<br>und the perimeter] mattress to   | F 2                 | 80  |  |     |                            |
|  | On 3/4/15 at 11:0<br>director of nursing<br>findings.  | 0 a.m., the administrator and g were made aware of the above  |                     |   |  |     |                            |
|  | documented, "CC<br>The approaches<br>specific and indiv<br>Managing falls ca<br>not have a single<br>combination of ris<br>Regardless of the<br>place, a key factor  | document, "PHASE 1 ASSESS" OMPREHENSIVE CARE PLAN: for fall interventions are clear, idualized for the patient's needs. in be complex as many falls do cause but include a sk factors and causes. interventions that are put into or to success is the timely review ins as the patient's condition and |                     |   |  |     |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                     |   | (X3) DATE SURVEY<br>COMPLETED |                             |
|--|--|--|---------------------|---|-------------------------------|-----------------------------|
|  |  | 495045   | B. WING_            |   | 03/                           | /04/2015                    |
|  | PROVIDER OR SUPPLIER<br>C <b>ARE HEALTH SERVI</b>  | CES-STRATFORD HALL REVIS   | ED                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228   |                               |                             |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)   | ) 日巨                          | (XIS)<br>COMPLETION<br>DATE |
| F 280  | On 3/4/15 at 2:10 p. a copy of Resident administrator confineresolved from the calinterview with RN #5   | m., the administrator provided<br>#7's updated care plan. The<br>med the fall mats were<br>are plan after this surveyor's<br>3.  | F 28                |   |                               |                             |
| F 281<br>SS=D  | 483.20(k)(3)(i) SER<br>PROFESSIONAL S<br>The services provide  | on was presented prior to exit. VICES PROVIDED MEET TANDARDS  ed or arranged by the facility onal standards of quality.  | F 28                | It is the intended practice of the facilir<br>provide services that meet professions<br>standards of quality.   | ty to                         | 04/18/15                    |
|  | by: Based on observation document review, it facility staff failed to of practice during more of 5 nursing units (the LPN (licensed praction top of the medical practice). | cal nurse) #2 left medications<br>tion cart and the cart<br>ervised during the medication<br>the 600 unit.   |                     | Criteria 1 Incident report completed for Resident MD notified with no new orders.  Resident #20 received her medications ordered.  LPN#2 educated on not leaving medications unsupervised and on not leaving medication cart unlocked during medication administration to ensure the safety of Residents #27 and #28. | s as                          |                             |
|  | the 600 nursing unit<br>administration obser<br>was observed in the<br>drawers/front side fa<br>hallway. The cart wa   | m., the surveyor arrived on for the medication vation. A medication cart hallway, against the wall, the cing out towards the open is observed unlocked. An was on top of the cart. |                     |   |                               |                             |

|  |  | THE PARTY OF THE P |                                       |  | OWR M  | J. 0938-038                |
|--|--|--|---------------------------------------|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDE AND PLAN OF CORRECTION IDENTIFIES |  | (X1) PROVIDER/SUPPLIER/CLIA<br>(DENTIFICATION NUMBER:  |                                       | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED  |                            |
|  |  | 495045   | B. WING                               |  |  | 3/04/2015                  |
| NAME   | OF PROVIDER OR SUPPLIER  |  | · · · · · · · · · · · · · · · · · · · | STREET ADDRESS, CITY, STATE, ZIP COD   | <del>V.</del>  | 3/04/2015                  |
| MANO   | RCARE HEALTH SERV  | /ICES-STRATFORD HALL REVIS   | SED                                   | 2125 HILLIARD ROAD<br>RICHMOND, VA 23228   | _  |                            |
| (X4) II<br>PREFI<br>TAG  | X (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                   | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE  | (XS)<br>COMPLETION<br>DATE |
| F 28   | Under this cup wer "hydrocodone 7.5 r pain medication), " (milliequivalents) (treplacement), and treat high blood prefor Resident #20).  On 3/3/15 at 5:07 p services) walked by drawer that was slig On 3/3/15 at 5:08 p the cart in her wheeled on 3/3/15 at 5:10 p. Practical Nurse #2)  At this time (5:11 p. down the half to the turning the cart so the turning the cart so the turning the cart so the resident's room, in the sident's room, in the way with his real was not locked. LPI medications for anothe inverted drinking remained on top of the inverted drinking cup. When medications were for Resident #20)." At the following medications medications were for Resident #20)." At the following medications medications were for Resident #20)." At the following medications "Neurontin 300 mg (in the pain was not locked." | re the following medications: mg, (milligrams) (a narcotic potassium 20 meq used for potassium "hydralazine 25 mg. (used to essure) (the medications were  a.m., a staff member (social of the cart and pushed in a ghtly cracked open.  a.m., Resident #27 went past elichair.  a.m., LPN #2 (Licensed returned to the cart.  m.), LPN #2 moved the cart room of Resident #19, he drawers faced towards the he doorway of the room. LPN elling the lock on the cart out hand, and did not attempt to the cart, indicating the cart N #2 was observed preparing ther resident (Resident #19). eling cup containing medications he cart. He picked the cup clearly revealed that a aining pills was under the asked what resident the r, he stated, "(name of his time, he prepared the s for Resident #19: used to treat neuropathy).  | F 281                                 |  | ot leaving a not i while while ons ot i and on ked of it / x4 d report i |                            |
|  | *Neurontin 300 mg (use<br>*Nexium 40 mg (use<br>*Oxycodone 10 mg (i  | used to treat neuropathy).   |                                       |  |  |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | YPLE CONSTRUCTION  VG   |             | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---------------------|---|-------------|-------------------------------|--|
|  |  | 495045   | B. WING             |   | 03          | /04/2015                      |  |
| NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-STRATFORD HALL REVIS |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP C<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228              | ;QDE        |                               |  |
| (X4) ID<br>PRÉFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE | COMPLETION<br>DATE            |  |
| F 281  | *Tylenol (used to locate any for the inverted drinking (now having 2 inv medications on to and #19), and left unlocked to obtain This was approximately 5:2 cart and administration Resident #19.  After administerin LPN #2 was obse Resident #20 insk then moved the care Resident #28 (applaced the medication Resident #28, the doorway facing Interpretated the follow #28: *aspirin 81 m*Tylenol 650 mg, avitamin deficiency the medication care (used to replace administer the resit. He then left the medication room for 5:30 p.m LPN #2 unsupervised. He approximately 5:30 Con 3/4/15 at 3:08 conducted with LP nervous about belinave left meds (minus for the medication for the province of t | then searched the cart for treat pain) and was not able to resident. He then placed an up over the cup of medications, erted drinking cups covering p of the cart - for Resident #20 the cart unsupervised and in the Tylenol from the stat box. nately 5:20 p.m. At 3 p.m., LPN #2 returned to the ered the prepared medications of the medications for the medication cart. LPN #2 art down to the room for cart was positioned in the room for cart was positioned in the wing medications for Resident g (used to prevent blood clots), and ***Thera M multivitamin (for it for *caltrate with Vitamin D alcium and vitamin D) to ident but was unable to locate cart again, to search the or caltrate at approximately 2 left the cart unlocked and returned to the cart at | F 28                |   |             |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                     |          |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---------------------|----------|---|-------------------------------|----------------------------|
|   |   | 495045   | B. WING             |          |   | 07                            | 3/04/2015                  |
|   | E OF PROVIDER OR SUPPI<br>NORCARE HEALTH SE   | LIER<br>ERVICES-STRATFORD HALL REVIS   | ED                  | 2125     | ET ADDRESS, CITY, STATE, ZIP O<br>HILLIARD ROAD<br>IMOND, VA 23228                            |                               | 70-72015                   |
| PRE   | FDX (EACH DEFICE  | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | <b>«</b> | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE                     | (XS)<br>COMPLETION<br>DATE |
|   | medications we the surveyor init LPN #2 was not LPN #2 was not A review of the the Administration: "lock medical nurse administe the facility policy Administration of "Medications a stored in a lockeroom, accessible and maintained actively utilized a for medication and Assistant Diale aware of the find provided by the example of the find provided by the example amputation, in osteoporosis, and most recent MDS annual assessment Reference Date) coded as being chaily life decisionarequiring limited as policy in the example of the find annual assessment requiring limited as find the store of the find annual assessment for the find annual annua | the cart was unlocked and re unsupervised on top of it when taily approached the cart, and a present, he made no comment.  facility policy "Medication Medication Pass" documented, tion cart when not in direct view of ring medication" A review of ring medication and Treatment Suidelines" documented, and biologicals are securely and cabinet, cart or medication as only to licensed nursing staff under a lock system when not and attended to by nursing staff | F 2                 | 81       |   |                               |                            |
|   | Resident #27 was<br>10/19/14 with the<br>diabetes, high blo   | admitted to the facility to<br>diagnoses of but not limited to<br>od pressure, schizophrenia,<br>eep vein thrombosis. The most   |                     |          |   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                          |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                     |  | (X3) DATE SURVEY<br>COMPLETED   |                    |
|---|--------------------------|--|--|---------------------|--|---------------------------------|--------------------|
|   |                          | :  | 495045   | B. WING_            |  | ,                               | 3/04/2015          |
|   |                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI  | CES-STRATFORD HALL REVIS   | SED                 | STREET ADDRESS, CITY, STATE, Z<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 | IP CODE                         | <u>13104120 13</u> |
|   | (X4) ID<br>PREFIX<br>TAG | EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC    | ION SHOULD BE<br>HE APPROPRIATE | COMPLETION<br>DATE |
|   | i i a sa a h             | intact in ability to ma resident was coded assistance for bathin mobility; limited assistance; and supervision Resident #19 was as 8/25/14 with the diagparaplegia, chronic of disease, high blood paraplegia, chronic of disease, high blood paraplegia, chronic of disease, high blood paraplegia, chronic of disease, high blood passessment with an assessment with an assessment with an assessment with an extensive assistance dressing, and transferentially.  Resident #28 was ad 12/18/13 with the diagnigh blood pressure, and deep vein thromit was an annual assessively impaired in lecisions; and was consistance for transferential series and supervising and | Resident #27 as cognitively ake daily life decisions. The as requiring extensive as requiring extensive as requiring extensive as the control of the facility on the facility on the composes of but not limited to obstructive pulmonary pressure, and a pressure and MDS was an annual ARD of 2/8/15. The resident extensively intact in ability to make and was coded as requiring a for bathing, hygiene, are; and limited assistance for imitted to the facility on gnoses of but not limited to arthritis, thromboembolus, cosis. The most recent MDS sment with an ARD of ant was coded as severely a ability to make daily life coded as requiring total are out of bed; extensive obility, dressing, and sion for eating.  The most recent make daily life coded as requiring total are out of bed; extensive obility, dressing, and sion for eating.  The most recent make daily life coded as requiring total are out of bed; extensive obility, dressing, and sion for eating.  The most recent make daily life coded as requiring total are out of bed; extensive obility, dressing, and sion for eating. | F 28                |  |                                 |                    |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|--|--|-------------------------------|--|
|                          |  | 495045   | B. WING_                               |  | 03/04/2015                    |  |
|                          | PROVIDER OR SUPPLIER   | ICES-STRATFORD HALL REVIS  | ED                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228                        |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION                 |  |
| F 281                    | Fundamentals of and Practice, 4th ed Inc., page 376, by F Griffin Perry: "Medibe left unattended, observed taking the According to Funda edition, 2001: Patric Perry, Mosby, Inc., and Safe Narcotic Admir all narcotics in a loc container."  *Information obtaine 2009, Prentice Hall, 755, 1152, and 1259  **Information obtaine http://www.nlm.nih.gs/a603032.html  ***Information obtaine http://www.pharmacys-8274.htm 483.25 PROVIDE C/HIGHEST WELL BE Each resident must reprovide the necessar or maintain the higher mental, and psychos | Nursing: Concepts, Process, it. St Louis: Mosby-Year Book, Potter, Patricia A., and Anne cations of any sort should not and patients should be medication."  mentals of Nursing, 6th cia A. Potter and Anne Griffen page 828, "Guidelines for nistration and Control: Store ked, secure cabinet or ked, secure cabinet or pages 9, 222, 593, 698, 752, and from how/medlineplus/druginfo/med led from cov/medlineplus/druginfo/med led from cov/medlineplus/drugin | F 28                                   |  | ity<br>to<br>le               |  |
|                          | This REQUIREMENT   | is not met as evidenced  |  |  |                               |  |

|   |  | - a werman arrivatora   |               |  | OWRING   | ). 0938-039                |
|---|--|---|---------------|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |               |  | TE SURVEY<br>MPLETED   |                            |
|   |  | 495045  | B. WING_      |  | 03   | /04/2015                   |
| NAME OF   | PROVIDER OR SUPPLIER   |   | <u> </u>      | STREET ADDRESS, CITY, STATE, ZIP CO  | ODE  | 10-412013                  |
|   |  |   | ŀ             | 2125 HILLIARD ROAD   | JUL  |                            |
| MANOR   | CARE HEALTH SERV   | ICES-STRATFORD HALL REVIS   | SED           |  |  |                            |
|   | 731 48 48 44 49 44 45 45   |   | <u> </u>      | RICHMOND, VA 23228   |  |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)  | SHOULD BE  | (X5)<br>COMPLETION<br>DATE |
|   | by: Based on staff intereview, clinical recording that the facility staff pain assessment for survey sample, Resorted to assess and the findings include Resident #5 was administration of as January 2015.  The findings include Resident #5 was administration of assessment, a significant finding to thrive, dempulmonary disease, oblood pressure, deep inflammation of the gasessment, a significant finding assessment, a significant finding to the find | erview, facility document and review, it was determined failed to perform a complete or one of 28 residents in the sident #5.  Bed to offer all interventions prior to the needed pain medications and sident #5's pain using quality a non-verbal gestures, quality, stensity of pain) before the needed pain medication in the sident were not limited to:  In altered mental status, adult entia, chronic obstructive congestive heart failure, high ovein thrombosis, and pallbladder.  S (Minimum Data Set) ident change assessment. | F 30          | Resident #5's comprehensive assessment completed and car updated with non-pharmacold interventions.  Criteria 2 Residents at risk for pain will and reevaluated with measura quality descriptors for pain, as pharmacological interventions administration of pain medicar reassessed for effectiveness of pharmacological interventions medication administration.  Criteria 3 Nurses have been reeducated of Practice Guide, to include, but to: medication administration/documentation, physician orders, usage of non-pharmacological interventions medication administration and reassessment using quality indicassessment using quality indicassessments for completion we weeks and monthly x2 months | be identified ble criteria, and non — sprior to tion and fool not limited following — prior to ticators. |                            |
| -   | 12/29/14, coded the impaired to make dai resident was coded a assistance of one stactivities of daily living The physician orders  | ment reference date) of resident as being moderately ly cognitive decisions. The is requiring extensive ff member for all of her g. for January 2015, and an on 1/11/15, documented,  |               | to QAA committee for review a recommendations.  Criteria 5 The facilities alleged date of co April 18, 2015.   |  |                            |

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |                                 | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|--|--|---------------------------------|-------------------------------|--|
|                          |   | 495045   | B. WING                                |  | ۰,                              | 3/04/2015                     |  |
|                          | PROVIDER OR SUPPLIER  CARE HEALTH SERVI   | ICES-STRATFORD HALL REVIS  | ED                                     | STREET ADDRESS, CITY, STATE, Z<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |                                 | <del>0.042013</del>           |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                     |  | ION SHOULD BE<br>HE APPROPRIATE | COMPLETION<br>DATE            |  |
|                          | "MAPAP (Tylenol) 3 tabs (tablet) by mou a scheduled medical order documented, mg) by mouth every elevated temperature. Review of the Janual administration recorn "MAPAP (Tylenol) 2 every 6 hours as net temperature." It was given on 1/28/15 at 12:30 p.m. The reveany documentation of Tylenol.  Review of the nurse 1/31/15 did not documented for the medication after the medication after the medication after the medication of the medication after the medication of the medication of the medication of pains out, grimacing, crying the physician orders. Enfrequently to position | ath twice daily for pain." This is ation. A second physician "MAPAP (Tylenol) 2 tabs (650 of 6 hours as needed for re."  ary MAR (medication and revealed documented, tabs (650 mg) by mouth eded for elevated as having been 11:08 a.m. and 1/31/15 at are of the MAR did not reveal regarding the administration of or it, if non pharmacologic rovided or the effectiveness er receiving it.  care plan, dated, 1/2/15, and regarding the administration of or it, if non pharmacologic rovided or the effectiveness er receiving it.  care plan, dated, 1/2/15, and regarding the pain The mented, "Report nonverbal such as moaning, striking the pain medication per courage/Assist to reposition of comfort." | F 3                                    |  |                                 |                               |  |
|                          | nurse) #4 on 3/4/15 a<br>procedure the nursing<br>resident complains of   | ducted with RN (registered at 10:00 a.m. regarding what g staff should follow when a pain. RN #4 stated, "First the resident for the location, rel and then offer terventions, like  |  |  |                                 |                               |  |

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING   |   |                     | (X3) DATE SURVEY<br>COMPLETED   |                                 |                            |
|--------------------------|--|---|---------------------|---|---------------------------------|----------------------------|
|                          |  | 495045  | B. WING             |   | 0.2                             | 3/04/2015                  |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI  | ICES-STRATFORD HALL REVIS   | ED                  | STREET ADDRESS, CITY, STATE, ZI<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |                                 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFII<br>TAG |   | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|                          | repositioning. Give nurse has to go bacto see if the medical asked where all of the non-pharmacologic are documented on the the non-pharmacologic documented, RN #4 nurse's note in (name #4 was then asked the nurse's notes regard. Tylenol to Resident: MAR and nurses notes of the more pharmacologic effectiveness of the "No, it's not there."  An interview was constaff member (ASM) nursing, on 3/4/15 at process nursing sho complains of pain. An urse should assess and location of pain. Process nursing of pain. An interview was constaff member (ASM) nursing, on 3/4/15 at process nursing sho complains of pain. An interview was constaff member (ASM) nurse should assess and location of pain. An interview was relieved." When assessment, pain methe offering of non-ple documented, ASM #6 | the pain medication. The ck and reassess the resident tion is effective." When he assessment, interventions and medication N #4 stated, "It should be MAR." When asked where egic interventions are stated, "They should write a ne of computer program)." RN to review the MAR and the ding the administration of #5. RN #4 reviewed the tes and stated, "I don't see it on the front of the MAR." ocumentation on the MAR not interventions and medications. RN #4 stated, and the with administrative #3; the assistant director of 10:24 a.m. regarding the uld follow when a resident NSM #3 stated, "First the the resident; type, intensity, | F 3                 | 09  |                                 |                            |
| Ì                        | The facility policy, "Pa   | ain Practice Guide"   |                     |   | ļ                               | ]                          |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER:  A. BUILDING  |                     |  | (X3) DATE SURVEY<br>COMPLETED |                            | Η. |
|---|---|---|---------------------|--|-------------------------------|----------------------------|----|
|   |   | 495045  | B. WING             |  | ٥.                            | 3/04/2015                  |    |
|   | F PROVIDER OR SUPPLIER<br>RCARE HEALTH SERVI  | CES-STRATFORD HALL REVI   | SED                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228  | <u> </u>                      | 3/04/2013                  | -  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)  | 8E                            | (X5)<br>COMPLETION<br>DATE | ٠, |
| F 309   | documented, "Obtaine before and after admineded) analgesics the MARIntervention-pharmacologic Non-pharmacologic interventions can middications, permit result in discontinual "During an episode dassesses the location pain." Fundamentals & Potter, page 1241  The administrator and made aware of the administrator and at 11:06 a.m.  483.25(h) FREE OF HAZARDS/SUPERV  The facility must ensure environment remains as is possible; and eadequate supervision prevent accidents. | In pain scale scores daily and ministration of PRN (as . Scores are documented on ions include as well as pharmacologic, approaches used as initial inimize the need for use of the lowest does or tion of medications."  of acute pain the nurse of acute pain the nurse of Nursing, 6th edition, Perry and director of nursing were bove findings on 3/4/15 at  ACCIDENT ISION/DEVICES  ure that the resident as free of accident hazards ach resident receives and assistance devices to | F 323               | F323  It is the intended practice of this facility ensure that the resident environments remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  Criteria 1  Resident #9 has a revised care plan to | y to                          | 04/18/15                   |    |
|   | by:<br>Based on staff intervi<br>and clinical record rev<br>the facility staff failed in<br>a manner to promo:  | is not met as evidenced iew, facility document review riew, it was determined that to provide care and services te safety for two of 28 y sample, Resident #9 and   |                     | address fall prevention.  LPN#2 educated on not leaving medications unsupervised and on not leaving medication cart unlocked during medication administration to ensure the safety of Resident #27.  |                               |                            |    |

|               | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |               | PLE CONSTRUCTION<br>3  | (X3) DATE SURVEY<br>COMPLETED |   |
|---------------|--|---|---------------|--|-------------------------------|---|
|               |  | 495045  | B. WING       | B. WING  |                               |   |
| NAME OF       | PROVIDER OR SUPPLIER   | ₹   |               | STREET ADDRESS, CITY, STATE, ZIP CODE  | 03/04/2015                    | - |
| MANOR         | CARE HEALTH SER  | VICES-STRATFORD HALL REVIS  | ED !          | 2125 HILLIARD ROAD<br>RICHMOND, VA 23228   |                               |   |
| (X4) ID       |  | ATEMENT OF DEFICIENCIES   | i iD          | PROVIDER'S PLAN OF CORRECT   | ION (VIII)                    | _ |
| PREFIX<br>TAG | (EACH DEFICIENT<br>REGULATORY OR   | CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOU<br>GROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | LD BE COMPLÉTION              | 1 |
| F 323         |  | age 36<br>f failed to develop and   | F 323         | Criteria 2 All residents have the potential to b affected.   | e .                           | _ |
|               | implement interventions to prevent further falls for Resident #9 following falls on 11/15/14 and 11/19/14.   |   | . ,           | Residents with falls will be reviewe Eagle Room for care plan revisions updated as appropriate.  |                               |   |
|               | were secured in a<br>medication cart on<br>#27 was observed  | failed to ensure medications<br>safe manner on one<br>the 600 nursing unit. Resident<br>passing the cart with<br>cessible medications in her  |               | Nurses have been reeducated on not leaving medications unsupervised a not leaving medication cart unlocke while unattended.  Criteria 3  | ndon.                         |   |
|               | The findings include:  1. Resident #9 was admitted to the facility on 8/26/14 and most recently readmitted on 9/9/14   |   |               | IDT team has been reeducated by MDS/designee on revision of resider care plans.  Nurses have been reeducated on not  |                               |   |
| ·             | dementia, depressi<br>psychosis and beni<br>the most recent ME<br>quarterly assessme   | uding, but not limited to: on, high blood pressure, gn prostate enlargement. On DS (minimum data set), a ent with assessment reference  |               | leaving medications unsupervised at<br>not leaving medication cart unlocke<br>while unattended.  | nd on                         |   |
|               | severely cognitively<br>decisions. He was<br>for walking, and as<br>staff for bed mobility<br>and bathing. He wa   | ident #9 was coded as being impaired for making daily coded as being independent requiring the assistance of y, toileting, personal hygiene as coded as having one fall me fall with minor injury during i.                         |               | Criteria 4 The ADNS/designee will randomly resident's care plans related to falls x4 weeks and monthly x2 months ar report to QAA committee for review recommendations.  ADNS/designee will randomly audit   | weekly<br>ad<br>v and         |   |
| E<br>E        | revealed the following to the following to the following t | es' notes for Resident #9 ng note written on 11/15/14 at it was laid in the bed for a nap opeared to be sleepy and it did not sleep at night. ously pace (sic) the hallway doors seeking to go out. ity walking. Resident is a high | ;             | medication administration weekly x weeks and monthly x2 months and r to QAA committee for review and recommendations.  Criteria 5 The facilities alleged date of compliance of the compliance of | 4 eport                       |   |

|   |                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIET/CLIA<br>IDENTIFICATION NUMBER:   |                     | TIPLE CONSTRUCTION   |  | ATÉ SURVEY<br>OMPLETED     |
|---|--------------------------|--|---|---------------------|--|--|----------------------------|
| i |                          |  | 495045  | B. WING             |  |  | 3/04/2015                  |
|   |                          |  | ICES-STRATFORD HALL REVIS   | SED                 | STREET ADDRESS, CITY, STAT<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 | E. ZIP CODE                            | 3/U4/2013                  |
|   | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN (EACH CORRECTIVE, CROSS-REFERENCED 1 DEFICIE           | ACTION SHOULD BE<br>TO THE APPROPRIATE | (XS)<br>COMPLETION<br>DATE |
|   | t c C n s T s R n d      | Resident has three forehead, above rt. Resident also has a [Name of physician] were made aware. to the [name of loca (neurological) check all extremities. Resident resp. (respiratory) di as usual." [The CN/the time of this fall with during the survey.]  A review of the fall intrevealed that the fact the corner of the resident as a fall becaying in bed just prior he presence of the becomer.  On 3/4/15 at 12:20 p. surse) #4 was interviewed that Resident #6 tooked like he needed he remembered that tesident #9 into his beext time she saw the own the hall as described. | dent is very difficult to redirect abrasions: on the rt. (right) eyebrow and rt. lower back. cut on the lt. (left) eyebrow. and R/P (responsible party) Son said he will take resident I hospital]. Neuro is within normal limits, moving ident a/o (alert and oriented) is condition is stable. No stress. Resident is walking A working with Resident #9 at ras not available for interview evestigation dated 11/15/14 illty staff discovered blood on ident's night stand and on the d and the nightstand. The the facility staff treated this ause he had been observed to the fall, and because of blood on the nightstand.  The facility staff treated this ause he had been observed to the fall, and because of blood on the nightstand.  The was "very tired" and d a nap." She stated that the resident; he was walking ribed in her note. | F 32                | 23   |  |                            |
|   | in<br>re<br>th           | vealed instructions t  | by Room discharge ent #9 dated 11/15/14 o care for three stitches over the resident's left  |                     |  |  |                            |

|                          | FOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    | LTIPLE CONSTRUCTION  |                                   | ATE SURVEY<br>IMPLETED     |
|--------------------------|---|---|--------------------|--|-----------------------------------|----------------------------|
|                          |   | 495045  | B. WING            |  | 0:                                | 3/04/2015                  |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI   | ICES-STRATFORD HALL REVIS   | ED                 | STREET ADDRESS, CITY, STATE, 2<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |                                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL,  SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |  | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|                          | on 11/19/14 at 11:11 (certified nursing as and assisted [Resid closed the door. Apmin. (minutes) later coming from dining CNA observed [Reside chair. CNA nurse. Charge nurse pain/injury with none hitting head. Neuro normal limits. Reside position and assiste snack. MD (doctor) times with message A review of the com 9/17/14 and most rerevealed the following to the 11/15/14 fall: Provide assist to transeded Therapy orders. Attempt to resident. A review for the 11/15/14 and the resident's bed wobservation by a staresident had been as prior to both falls. A also revealed therap prior to the falls to st to walk without difficitals, Resident #9 has therapy services with supervision for ambutes. | aled the following note written 5 p.m.: "At start of shift, CNA sistant) was making rounds lent #9] back to bed and oprox (approximately) four CNA heard a loud noise area and went to assess. sident #9] sitting on the floor than (sic) went to get Charge se assess (sic) resident for a noted. Resident denies checks initiated and within dent assisted to standing at to sit in chair and offered a left to call back to facility."  prehensive care plan dated beently updated on 1/22/15 and interventions for falls prior "Bed in low position | F3                 |  |                                   |                            |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1                   | TIPLE CONSTRUCTION  |                                   | TE SURVEY<br>MPLETED       |
|--------------------------|---|--|---------------------|---|-----------------------------------|----------------------------|
|                          |   | 495045   | B. WING             |   | 0.7                               | 3/04/2015                  |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERV  | ICES-STRATFORD HALL REVIS  | ED .                | STREET ADDRESS, CITY, STATE, Z<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228        |                                   | 10-11-01-0                 |
| (X4) ID<br>PREFIX<br>TAG | (ÉACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFID<br>TAG | PROVIDER'S PLAN OF<br>X (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|                          | referenced falls. On 3/4/15 at 12:20 nurse) #4, who was Resident #9 resides the process of putting place to prevent fur sustains a fall. She responsible for upda usually the unit mar director of nursing) nursing) decides on stated: "I don't know [Resident #9]."  On 3/4/15 at 2:05 p. member) #2, the DO were interviewed reginterventions into pla after a resident sust that the facility staff of thinking though a coming up with new safety. She stated a coming up with new safety. She stated a had happened in the ASM #2 was intervie facility staff treated the resident had bee that there was blood stand and on the flood a fall. ASM #2 stated any new intervention record. She describe wice-a-day "Eagle R resident incidents/sta | p.m., LPN (licensed practical working on the unit where s, was interviewed regarding ng new interventions into ther falls after a resident stated that everyone is atting the care plan, but that pager, the ADON (assistant or the DON (director of the new interventions. She w what else to do for him am., ASM (administrative staff DN, and ASM #3, the ADON, garding putting new lace to prevent further falls ains a fall. ASM #3 stated usually does a very good job resident's care plan and interventions to promote the did not understand what above referenced instances. In the second second in the second in | F3                  | 23  |                                   |                            |

| STATEMEN<br>AND PLAN     | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILDI | TIPLE CONSTRUCTION<br>ING  |                                   | ATE SURVEY<br>OMPLETED |
|--------------------------|---|---|-----------------------|--|-----------------------------------|------------------------|
|                          |   | 495045  | B. WING               |  |                                   | 3/04/2015              |
| 1                        | PROVIDER OR SUPPLIER  CARE HEALTH SERV  | CES-STRATFORD HALL REVIS  | ED .                  | STREET ADDRESS, CITY, STATE, 2<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228     |                                   | <del></del>            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG         | PROVIDERS PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | COMPLETION<br>DATE     |
|                          | remembered discus Room, but admitted documentation of the resident's record. As a fall risk assessme above referenced fanot provide one bed perform them.  On 3/4/15 at 3:20 p. administrator, and Asthese concerns. Por regarding new intervious of the facility Practice Guide" reventing a fall were approaches for specific and individual Managing falls can be not have a single can combination of risk for Regardless of the interventions an eeds change."  According to Mosby's Care Assistants, four "Safety is a basic needs at great risk for faccidents | is sing these falls in the Eagle I that there was no lese discussions in the ISM #2 was asked to provide Int for Resident #9 prior to the Isl. She stated that she could ause the facility does not  In., ASM #1, the Isl #2 were informed of Islicies and procedures rentions to promote safety requested.  It policy entitled "Falls realed, in part, the following: If all interventions are clear, Islicied for the patient's needs. It is complex as many falls do use but include a actors and causes. It reventions that are put into a success is the timely review is the patient's condition and I Textbook for Long-Term th edition, 2003. Page 144, Ind. Nursing center residents | F 33                  | 23   |                                   |                        |
|                          | 2. The facility staff fa<br>vere secured in a saf   | iled to ensure medications  |                       |  |                                   |                        |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | I .                 | TIPLE CONSTRUCTION ING   |                                   | NTE SURVEY<br>IMPLETED     |  |
|--------------------------|---|--|---------------------|--|-----------------------------------|----------------------------|--|
|                          |   | 495045   | B. WING             |  | 0:                                | 3/04/2015                  |  |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERV  | ICES-STRATFORD HALL REVIS  | ED                  | STREET ADDRESS, CITY, STATE, 2<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |                                   |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFID<br>TAG |  | TION SHOULD BE<br>THE APPROPRIATE | (XS)<br>COMPLETION<br>DATE |  |
| F 323                    | Continued From pa   | ige 41   | F 3                 | 23   |                                   |                            |  |
|                          | #27 was observed  | the 600 nursing unit. Resident passing the cart with cessible medications in her   |                     |  |                                   |                            |  |
|                          | 10/19/14 with the diabetes, high blood depression, and de recent MDS (Minim assessment with ar Reference Date) of coded as being cog daily life decisions, requiring extensive bathing; limited ass | admitted to the facility to lagnoses of but not limited to d pressure, schizophrenia, ep vein thrombosis. The most um Data Set) was a quarterly a ARD (Assessment 1/26/15. The resident was initively intact in ability to make The resident was coded as assistance for dressing and istance for transfers out of n for eating and hygiene. |                     |  |                                   |                            |  |
|                          | 2/15/08 with the dia leg amputation, high osteoporosis, and c most recent MDS w with an ARD of 2/22 as being cognitively life decisions. The requiring limited ass                                  | idmitted to the facility on gnoses of but not limited to blood pressure, cronary artery disease. The as an annual assessment 1/15. The resident was coded intact in ability to make daily resident was coded as distance for dressing and afters, eating, and hygiene.   |                     |  |                                   |                            |  |
|                          | the 600 nursing unit<br>administration obset<br>was observed in the<br>drawers/front side fa<br>hallway. The cart was<br>inverted drinking cup<br>Under this cup were                               | m., the surveyor arrived on for the medication vation. A medication cart hallway, against the wall, the acing out towards the open as observed unlocked. An owas on top of the cart. the following medications: g, (milligrams) (a narcotic  |                     |  |                                   |                            |  |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPI<br>A. BUILDING | LE CONSTRUCTION  |                             | TE SURVEY<br>MPLETED       |
|--------------------------|--|---|-----------------------------|--|-----------------------------|----------------------------|
|                          |  | 495045  | B. WING                     |  | 07                          | /04/2015                   |
|                          | PROVIDER OR SUPPLIE<br>CARE HEALTH SER   | R<br>VICES-STRATFORD HALL REVIS   | SED 2                       | TREET ADDRESS, CITY, STATE, ZIP<br>H25 HILLIARD ROAD<br>RICHMOND, VA 23228                 |                             | //V4/2015                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES IY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>EAPPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|                          | pain medication), (milliequivalents) (replacement), and treat high blood properties of the cast high blood properties of the cast in her when the cast in her picked the clearly revealed a new as under the drink | rpotassium 20 meq used for potassium "hydralazine 25 mg. (used to essure) (the medications were  o.m., a staff member (social y the cart and pushed in a ghtly cracked open.  o.m., Resident #27 went past elchair.  o.m., LPN #2 (Licensed returned to the cart.  o.m., LPN #2 was observed ons for another resident e inverted drinking cup ons remained on top of the cup up, and in doing so, nedication cup containing pills ing cup. When asked what tions were for, he stated. | F 323                       |  |                             |                            |
| i i                      | conducted with LPN<br>nervous about being<br>nave left meds (med<br>unattended or the consistency<br>fiscussed that the consistency<br>nedications were un<br>he surveyor initially<br>PN #2 was not present<br>a review of the facility   | m., an interview was #2. He stated he was watched and should not lications) on top of the cart, art unlocked. When it was art was unlocked and asupervised on top of it when approached the cart, and sent, he made no comment.  y policy "Medication cation Pass" documented.  |                             |  |                             |                            |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                  | LTIPLE CONSTRUCTION<br>DING  |                                   | ATE SURVEY<br>EMPLETED     |
|--------------------------|---|---|--------------------|--|-----------------------------------|----------------------------|
|                          |   | 495045  | B. WING            | í  | 0:                                | 3/04/2015                  |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERV  | ICES-STRATFORD HALL REVIS   | ED                 | STREET ADDRESS, CITY, STATE,<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |                                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |  | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|                          | "lock medication nurse administering the facility policy "M Administration Guid "Medications and stored in a locked or room, accessible or and maintained und actively utilized and for medication administration administration administration administration administration administration administration administration administration administration, 201: Participent, page 376, by Poministration and Practice, 4th edition, page 376, by Poministra | cart when not in direct view of a medication" A review of ledication and Treatment ledines" documented, biologicals are securely abinet, cart or medication only to licensed nursing staff ler a lock system when not attended to by nursing staff inistration"  Im., the Director of Nursing tor of Nursing were made as. No further information was of the survey.  Imentals of Nursing" 7th ia A. Potter and Anne Griffin lage 703. "Make sure that all booked containers in a room om) or are under constant  ation obtained from lursing: Concepts, Process, St Louis: Mosby-Year Book, otter, Patricia A., and Anne cations of any sort should not and patients should be | F3                 | 23   |                                   |                            |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                   | TIPLE CONSTRUCTION NG   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|---------------------|---|-------------------------------|
|                          |  | 495045  | B. WING_            |   | 03/04/2015                    |
| i                        | PROVIDER OR SUPPLIER  CARE HEALTH SERV   | ICES-STRATFORD HALL REVIS   | SED                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICIENCY)   | D BE COMPLETION               |
| F 323                    | *Information obtains<br>2009, Prentice Hall,<br>**Information obtain<br>http://www.nlm.nih.s<br>s/a603032.html   | ed from Nurse's Drug Guide<br>, pages 752, 755, and 1259.<br>ned from<br>gov/medlineplus/druginfo/med<br>ned from   | F 32                | 3   |                               |
|                          | http://www.pharmads-8-8274.htm 483.25(k) TREATMINEEDS The facility must ensproper treatment anspecial services: Injections; Parenteral and enter Colostomy, ureferos Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT by: Based on observation document review and was determined that administer oxygen acfor three of 28 resider Residents #7, #11 and 1. Resident #7 was of the care in the c | eyhealth.net/d/thera-m-vitamin ENT/CARE FOR SPECIAL sure that residents receive d care for the following rai fluids; tomy, or ileostomy care;  It is not met as evidenced en, staff interview, facility of clinical record review, it the facility staff failed to ecording to physician's orders ents in the survey sample, d #10. | F 32                | It is the intended practice of this facilit that residents receive the proper treatm and care for the following special serv injections; parenteral and enteral fluids colostomy, ureterostomy, or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; prostheses.  Criteria 1  Resident #7, #11, and #10 oxygen corrected to be administered per physorder. | nent<br>ices:<br>s;<br>and    |
| - [•                     | occasions during the   | bserved on separate<br>survey with the oxygen flow<br>liter and two liters per  | .                   |   |                               |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIP<br>A. BUILDING | PLE CONSTRUCTION  |                                    | E SURVEY<br>MPLETED        |
|--------------------------|--|---|----------------------------|---|------------------------------------|----------------------------|
|                          |  | 495045  | B. WING                    |   | 03/                                | 04/2015                    |
|                          | PROVIDER OR SUPPLIEF<br>CARE HEALTH SER  | VICES-STRATFORD HALL REVIS  | en :                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228   |                                    |                            |
| (X4) ID<br>PREFIX<br>TAG | (ÉACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | BE                                 | (X5)<br>COMPLETION<br>DATE |
|                          | minute; the physic per minute.  2. Resident # 13 w occasions during trate set at 1 1/2 lith minute; the physic liters a minute conditions a minute conditions a minute conditions a minute conditions during trate set between 1 the physician order. The findings included 1. Resident #7 was occasions during trate set between of minute; the physician order includes the physician conditions are set between of minute; the physician minute.  Resident #7 was at 10/20/11 and most with diagnoses that to: osteoporosis, provided the resident for a quarterly as (assessment reference the resident's cognimpaired. Section or requiring extensive bed mobility, transformed the resident of Review of Resident Review of Revie | vas observed on separate the survey with the oxygen flow ers per minute and at 3 liters a lians order was for oxygen at 2 tinuously.  as observed on separate the survey with the oxygen flow .5 and 2.0 L/min (liter/minute); r was for 2L/min.  de:  a observed on separate the survey with the oxygen flow ne liter and two liters per an's order was for two liters  dmitted to the facility on recently readmitted on 2/11/15 tincluded but were not limited neumonia and glaucoma. It recent MDS (minimum data sessment with an ARD ence date) of 2/18/15, coded ition as being severely G coded Resident #7 as assistance of one staff with ers and locomotion. Section O sident received oxygen | F 328                      | Criteria 2 All residents on oxygen was reviewed validate that they were administered correct dosage of oxygen per physicity order.  Criteria 3 Licensed nursing staff will be reeduced on reading and verifying oxygen on amount of liters prescribed by physical criteria 4 ADNS/designee will randomly audit residents on oxygen weekly x4 week monthly x2 months and report to QA committee for review and recommendations.  Criteria 5 The facilities alleged date of compliant April 18, 2015. | an<br>cated<br>cian.<br>s and<br>A |                            |
|                          |  | times 48 hours. Another   |                            |   |                                    | 1                          |

| STATEMENT OF DEFICIENCIES (X1)<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    | LTIPLE CONSTRUCTION DING   |  | ATË SURVEY<br>DMPLETED     |
|--|---|---|--------------------|--|--|----------------------------|
|  |   | 495045  | B. WING            |  | - 1 o:                                 | 3/04/2015                  |
|  | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI   | CES-STRATFORD HALL REVIS  | ED                 | STREET ADDRESS, CITY, STAT<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |  |                            |
| (X4) ID<br>PREFIX<br>TAG                                 | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | ACTION SHOULD BE<br>TO THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|  | physician's order da documented an ord minute via nasal ca shortness of breath level** below 90 per Resident #7's compon 11/29/12 docume acute respiratory dis Administer oxygen poserved sitting up a cannula on. The ox between one liter and the ball in the flow mark and the two liter and two liter mark.  On 3/4/15 at 9:20 and conducted with RN (was asked where the concentrator flow meresident has an orde #3 stated the middle the two line but some concentrator. At this Resident #7's oxygen the flow meter was seve level but two liter on 3/4/15 at 9:28 a.n. | ated 3/3/15 at 8:45 p.m. er for oxygen at two liters per nnula* as needed for or an oxygen saturation reant.  rehensive care plan initiated ented, "Goal: I will have no stress. Interventions: per physician order"  m., Resident #7 was n bed with an oxygen nasal ygen concentrator was set at two liters as evidenced by neter between the one liter er mark.  m., Resident #7 was n bed with a nasal cannula ncentrator was set between rs as evidenced by the ball in een the one liter mark and the  m., an interview was registered nurse) #3. RN #3 e ball in the oxygen ster should be positioned if a r for oxygen at two liters. RN of the ball should be right on a fluctuate based on the time, RN #3 was shown n concentrator. RN #3 stated et at one and a half liters at s if you look up. | F3                 | 328  |  |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRUCTION NG  |                                   | TE SURVEY<br>MPLETED       |
|---|---|--|---------------------|--|-----------------------------------|----------------------------|
|   |   | 495045   | B. WING             |  | 03                                | /04/2015                   |
|   | PROVIDER OR SUPPLIER CARE HEALTH SERV   | ICES-STRATFORD HALL REVIS  | SED                 | STREET ADDRESS, CITY, STATE,<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228     |                                   | 7742010                    |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|   | and the two liter materials and the two liter materials at 11:00 adirector of nursing varied findings.  The oxygen concentrations docume read the flow meter, rate line on the flow knob until the ball rist the ball on the L/mir prescribed"  The facility policy titt OXYGEN ADMINIST part, "PREPARATIO oxygen concentrator on and set flow meter extracts oxygen from No further information."  A nasal cannula is to the oxygen device through the nose." If from the website: http://www.thoracic.or/resources/oxygen-th/"The oxygen saturator how much oxygen information was obtainttp://www.thoracic.oresources/pulse-oxiresource | between the one liter mark ark.  a.m., the administrator and were made aware of the above strator manufacturer's ented, "NOTE: To properly, locate the prescribed flow meter. Next, turn the flow ses to the line. Now, center in (liter per minute) line.  ed, "RESPIRATORY: TRATION" documented in NOF EQUIPMENT: 3. For it, plug in power cord, turn unit er to correct flow rate in room air"  on was presented prior to exit. It is a two-pronged tube attached in for delivering oxygen. This information was obtained org/patients/patient-resources iterapy.pdf  tion level is a measurement your blood is carrying. This ined from the website: rg/patients/patient-resources metry.pdf | F 32                | 28   |                                   |                            |
|   |   | observed on separate survey with the oxygen flow   |                     |  |                                   |                            |

|   |                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1                 | LTIPLE CONSTRUCTIO                                 |  |        | ATE SURVEY<br>MPLETED                   |
|---|--------------------------|--|--|-------------------|--|--|--------|---|
|   |                          |  | 495045   | B. WING           |  |  | 0:     | 3/04/2015                               |
| 1 |                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI  | ICES-STRATFORD HALL REVIS  | ED                | STREET ADDRESS,<br>2125 HILLIARD R<br>RICHMOND, VA |  |        | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
|   | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | X } (EACH CC                                       | DER'S PLAN OF CORRECTIVE ACTION SHO<br>FERENCED TO THE APPR<br>DEFICIENCY) | ULD BE | (X5)<br>COMPLETION<br>DATE              |
|   |                          | rate set at 1 1/2 liter minute; the physicial liters a minute contil Resident #13 was a 6/11/2014. Diagnostimited to: hemipleg hypertension (high I fallure, depression, (mini-stroke), anem dementia. The most recent ME quarterly assessmentered to the most recent with a BIMS Status) score of 15 dindicating the resident was coded assistance with all A except for feeding with a supervision. Resident #13 was of pm. The resident was a nasal cannula. The resident masal cannula the Ozoncentrator was obstituted to the most recent mass of the physician's order documented, "6/12/2 liters)/MIN (minute) wontinuously." Review of the Medical | rs per minute and at 3 liters a ans order was for oxygen at 2 nuously. Idmitted to the facility on es included but were not ia (paralysis) of the left leg, blood pressure), kidney galibladder inflammation, TIA ia, CHF (heart disease) and DS (minimum data set), a nt, with an assessment D) of 1/22/2015 coded the G (Brief Interview for Mental on a scale of 0-15, 15 nt was cognitively intact. I as requiring extensive DLs (activities of daily living) hich was coded as requiring the oserved on 3/3/2015 at 2:37 as in bed with O2 (oxygen) on The oxygen flow rate on the was observed set at 1 ½ and observation was made at at was sitting up in bed eating asal cannula, the oxygen ed set at of 2 liters/minute. It is served on 3/4/2015 at 7:55 eakfast with O2 on via a 2 flow rate on the oxygen served set at 3 liters/minute. Its dated 2/25/2015 at 21. Via nasal cannula atton Administration Record mented, "Oxygen at 2L/MIN at 12. Via nasal cannula atton Administration Record mented, "Oxygen at 2L/MIN at 12. Via nasal cannula atton Administration Record mented, "Oxygen at 2L/MIN at 12. Via nasal cannula atton Administration Record mented, "Oxygen at 2L/MIN at 12. Via nasal cannula atton Administration Record | F                 | 128  |  |        |   |

| İ | STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '              | TIPLE CONSTRUCTION  |                                | TE SURVEY<br>MPLETED       |
|---|--|---|---|--------------------|---|--------------------------------|----------------------------|
|   |  |   | 495045  | B. WING            |   |                                | là 4 tanà E                |
|   |  | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI   | CES-STRATFORD HALL REVIS  | ED                 | STREET ADDRESS, CITY, STATE, ZII<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228            | P CODE                         | /04/2015                   |
|   | (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFD<br>TAG | PROVIDER'S PLAN OF C<br>X (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T)<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|   |  | each shift on the da An interview was co am with RN (Registrasked how she reach "You get at eye lever the middle of the line Resident 13's oxyge little under 3 liters, le RN #5 was then ask assessing the oxyge She stated, "The nurassess the patient, osaturation), notify the O2 (oxygen) is above stated, "I have not asmorning."  An interview was coram with RN #4. She process of checking reading the flow metric he sat (oxygen saturation) when RN #4. She process of checking reading the flow metric han interview was contain with the ADON (Alursing), regarding the poygen flow meter and thould be checked. So check." The ADON theck it when they conto the room." The Athere the flow meter in the middle of the line oxygen concentration. | becomented by the facility staff ites of the observation. Inducted on 3/4/2015 at 10:10 ered Nurse) #5. RN #5 was if the O2 flow rate, she stated, if and make sure the ball is in e." When asked to check on flow rate, RN #5 stated, "A set me go check his order." Ited who was responsible for an flow rates for residents. Ited who was responsible for an flow rates for residents. Ited who was responsible for an flow rates for residents. Ited who was responsible for an flow rates for residents. Ited who was responsible for an flow rates for residents. Ited who was responsible for an flow rates for residents. Ited who was asked about the oxygen for residents and er. RN #4 stated, "We check ration) during assessment." Ited how to read the flow fineel down on your knees to asked where the flow meter a stated, "The O2 ball should e line." Ited when the oxygen flow rate is stated, "Get on eye level of the stated, "Nurses are to ome on and when they go whoon was then asked ball should be. She stated, ine." | F 3:               | 28  |                                |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                    |  | (X3) DATE SURVEY<br>COMPLETED  |                            |
|--|---|--|--------------------|--|--------------------------------|----------------------------|
| i  |   | 495045   | B. WING            |  | 03                             | 3/04/2015                  |
| Ì  | PROVIDER OR SUPPLIER  CARE HEALTH SERVI   | CES-STRATFORD HALL REVIS   | ED                 | STREET ADDRESS, CITY, STATE, ZII<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |                                |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |  | ÖN SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|  | read the flow meter rate line on the flow knob until the ball ri the ball on the L/mli prescribed" According to Funda Potter, 6th edition, pareated as a drug. It such as atelectasis drug, the dosage or should be continuous should routinely che verify that the client oxygen concentration medication administration." The administrator are were made aware of at 11:10 am. 3. Resident #10 was 7/23/09 and again of included anemia (low hypertension (high binellitus (high blood scholesterol), anxiety, asthma (disease that mental status, kidney as being cognitively imaking. Resident #1 extensive assistance of her activities of dai MDS entitled "Specia | , locate the prescribed flow meter. Next, turn the flow ses to the line. Now, center in (liter per minute) line mentals of Nursing, Perry and page 1122. "Oxygen should be has dangerous side effects, or oxygen toxicity. As with any concentration of oxygen isly monitored. The nurse ok the physician's orders to is receiving prescribed in. The six rights of ration also pertain to oxygen and DON (Director of Nursing) these findings on 3/4/2015 is admitted to the facility on 15/31/14 with diagnoses that | F                  | 328  |                                |                            |

#### PRINTED: 03/31/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID 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 495045 8. WING 03/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD MANORCARE HEALTH SERVICES-STRATFORD HALL REVISED RICHMOND, VA 23228 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 328 Continued From page 51 F 328 Observations on 3/3/15 at approximately 3:00 p.m. revealed Resident #10 sitting up in her bed receiving oxygen by a \*nasal cannula which was connected to an oxygen concentrator (a medical device used to deliver oxygen to those who require it.). Further observation of Resident #10's oxygen concentrator revealed the flow meter on the concentrator set between 1.5 (one and a half) and 2 (two) liters per minute. Observations on 3/3/15 at approximately 5:25 p.m. revealed Resident #10 lying in her bed, watching television receiving oxygen by a nasal cannula which was connected to an oxygen concentrator. Further observation of Resident #10's oxygen concentrator revealed the flow meter on the concentrator set between 1.5 (one and a half) and 2 (two) liters per minute. Observations on 3/4/15 at approximately 8:50 a.m. revealed Resident #10 sitting up in her bed. eating breakfast independently, receiving oxygen by a nasal cannula which was connected to an oxygen concentrator. Further observation of Resident #10's oxygen concentrator revealed the flow meter on the concentrator set between 1.5 (one and a half) and 2 (two) liters per minute. Observations on 3/4/15 at approximately 2:10

p.m. revealed Resident #10 lying in her bed, awake with the head of the bed slightly elevated receiving oxygen by a nasal cannula which was connected to an oxygen concentrator. Further

An observation on 3/4/15 at approximately 2:15

observation of Resident #10's oxygen concentrator revealed the flow meter on the concentrator set between 1.5 (one and a half)

and 2 (two) liters per minute.

| (X3) DATE SURVEY<br>COMPLETED |  |
|-------------------------------|--|
| /04/2015                      |  |
|                               |  |
| (XS)<br>COMPLETION<br>DATE    |  |
|                               |  |
|                               |  |
|                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '               | RIPLE CONSTRUCTION NG  |                                | ATE SURVEY<br>OMPLETED |
|---|---|---|---------------------|--|--------------------------------|------------------------|
|   |   | 495045  | B. WING             |  | 0                              | 3/04/2015              |
|   | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI   | CES-STRATFORD HALL REVIS  | <b>E</b> D          | STREET ADDRESS, CITY, STATE, ZIP<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228             |                                |                        |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | ON SHOULD BE<br>IE APPROPRIATE | COMPLETION<br>DATE     |
|   | Under "Interventions oxygen as ordered."  An interview was conurse) #3, nurse surapproximately 2:30 procedure was for eflow rate was correct checked at the begins anytime during the stread the flow rate or RN #3 stated, "The pass through the minasked to read oxygen concentrator and a half liters/minutant and a half liters/minutant the flowmeter, line on the flowmeter, line on the flowmeter, line on the L/min (liter per line) in the ball rises to on the L/min (liter per line). "Oxygen is a drug and monitored with the same dication."  The Administrator and made aware of these approximately 4:30 per line on the rinformation."  A nasal cannula control oxygen is a drug and monitored with the same dication." | breath), etc (etcetera) " s" it documented, "Administer Date initiated 08/05/2009."  Inducted with RN (registered pervisor on 3/4/15 at p.m. When asked what the insuring a resident's oxygen at RN #3 stated, "It should be noting of each shift and shift." When asked how to in the oxygen concentrator, line of the flow rate should ddle of the ball." RN #3 was in flow rate on Resident #10's in. RN #3 stated, "It's at one ute."  Dany) user manual for the indocumented, "To properly locate the prescribed flowrate in. Noxt, turn the flow knob the line. Now, center the ball or minute) line prescribed."  Is and Clinical Skills, 2nd and Potter 2000, page 936, and is administered and ame care as any other  Ind Director of Nursing were a findings on 3/4/15 at | F 32                | 28   |                                |                        |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |   |
|---|---|---|---|---|-------------------------------|---|
|   |   | 495045  | 8. WING                                 |   | 03/04/2015                    |   |
|   | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI   | CES-STRATFORD HALL REVIS  | en :                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228   |                               | *************************************** |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL. EGULATORY OR LSC IDENTIFYING INFORMATION)  TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |   | BE COMPLE   | ΞΤΙΟΝ                         |   |
| F <b>387</b>  | s/oxt/howdoes.<br>483.40(c)(1)-(2) FR   | .gov/health/health-topics/topic   | F 328                                   |   | 04/18/                        | /15                                     |
| SS=D  | once every 30 days<br>admission, and at le<br>thereafter.<br>A physician visit is c   | or seen by a physician at least for the first 90 days after east once every 60 days onsidered timely if it occurs a safter the date the visit was   |   | It is the intended practice of this facilit ensure that residents are seen by a physician at least once every 30 days f the first 90 days after admission, and a least once every 60 days thereafter.  Criteria 1 Physician for Resident #1 was reeducate on timely physician visits.   | or<br>t                       | į                                       |
|   | by:<br>Based on staff inter<br>and clinical record re<br>the facility staff failed  | T is not met as evidenced view, facility document review eview, it was determined that it to ensure timely physician esidents in the survey   | ,                                       | Criteria 2 All residents have the potential to be affected.  All physicians and Medical Record stawill be reeducated on timely physician visits.  |                               |   |
|   | examine Resident #' a period of 80 days. The findings include: Resident #1 was adn 4/25/08 with diagnos- limited to: intracrania (bone infection)* and disorder) **. Resider (minimum data set), an ARD (assessment | nitted to the facility on es that included but were not I (brain) injury, osteomyelitis dysphagia (swallowing at #1's most recent MDS a quarterly assessment with t reference date) of 12/15/14, cognition as being severely  |   | Criteria 3  All physicians and Medical Record starwill be reeducated on timely physician visits.  Criteria 4  Administrator/designee will randomly audit physician visits weekly x4 weeks monthly x2 months and report to QAA committee for review and recommendations.  Criteria 5  The facilities alleged date of compliant April 18, 2015. | s and                         |   |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | FIPLE CONSTRUCTION<br>NG   |                                  | TE SURVEY<br>MPLETED       |
|--------------------------|--|---|---------------------|--|----------------------------------|----------------------------|
|                          |  | 495045  | B. WING_            |  | 02                               | /04/2015                   |
|                          | PROVIDER OR SUPPLIER<br>CARE HEALTH SERV   | CES-STRATFORD HALL REVIS  | SED                 | STREET ADDRESS, CITY, STATE, ZI<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228          |                                  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENCY | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|                          | the physician (or not examine Resident: a period of 80 days. On 3/4/15 at 11:20 conducted with OS employee responsitions of the physician of the physician of the facility policy title PHYSICIAN VISITS documented in part, physician visits are to clinical record. GUII by a physician visit is convithin 10 days of the property of the physician of the first of the physician visit is convithin 10 days of the property of the physician visit is convithin 10 days of the property of the physician visit is convithin 10 days of the property of the physician visit is convithin 10 days of the property of the physician visit is convithin 10 days of the property of the physician visit is convithin 10 days of the property of the property of the property of the property of the property of the property of the property of the property of the physician visit is convitted in part, physician visit is convitted in the property of the property of the property of the property of the property of the physician visit is convitted in the physician visi | it #1's clinical record revealed<br>urse practitioner) did not<br>#1 from 10/29/14 until 1/17/15, | F 38                |  |                                  |                            |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | ALE CONSTRUCTION  |  | ATE SURVEY<br>DMPLETED     |
|--------------------------|---|--|---------------------|---|--|----------------------------|
|                          |   | 495045   | B. WING             |   | 0  | 3/04/2015                  |
|                          | PROVIDER OR SUPPLIER  CARE HEALTH SERV  | ICES-STRATFORD HALL REVIS  | :En   2             | STREET ADDRESS, CITY, STATE, ZIP COOK<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)   | OULD 8E  | (XS)<br>COMPLETION<br>DATE |
| F 387                    | Continued From pa   | ge 56  | F 387               |   |  |                            |
|                          | website: http://www.nlm.nih.gorders.html 483.60(b), (d), (e) Electric LABEL/STORE DRIVED The facility must emailicensed pharmac of records of receipt controlled drugs in saccurate reconciliating records are in order controlled drugs is not reconciled.  Drugs and biological labeled in accordance professional principle appropriate accessor instructions, and the applicable.  In accordance with Sfacility must store all locked compartment controls, and permit thave access to the k.  The facility must provide the second controls and permit that the second controls are the k. | uploy or obtain the services of list who establishes a system that and disposition of all sufficient detail to enable an on; and determines that drug and that an account of all naintained and periodically as used in the facility must be see with currently accepted es, and include the ry and cautionary expiration date when state and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to | F 431               | records of receipt and disposition controlled drugs in sufficient deta enable an accurate reconciliation; determines that drugs records are and that an account of all controll is maintained and periodically records are and that an account of all controll is maintained and periodically records are and that an account of all controll is maintained and periodically records are all drugs and biologacordance with currently accepted professional principles, and include appropriate accessory and caution instructions, and the expiration data applicable.  It is also the intended practice of the facility to store all drugs and biologacordance with State and Federal locked compartments under proper temperature controls, and permit cauthorized personnel to have accelled the permanently affixed compartments storage of controlled drugs in Scheroscopic and provide separately locked permanently affixed compartments. | a licensed em of of all oil to and in order ed drugs conciled.  this ogicals in ed le the eary te when his ogicals in l laws, in er only ss to the d, s for edule II | 04/18/15                   |
|                          | confrolled drugs liste<br>Comprehensive Drug<br>Control Act of 1976 a<br>abuse, except when to<br>backage drug distribu   | d in Schedule II of the JAbuse Prevention and Ind other drugs subject to the facility uses single unit Ition systems in which the imal and a missing dose can  |                     | of the Comprehensive Drug Abuse<br>Prevention and Control Act of 197<br>other drugs subject to abuse, except<br>the facility uses single unit packag<br>distribution systems in which the of<br>stored is minimal and a missed do<br>readily detected.  | e<br>76 and<br>pt when<br>se drug<br>quantity  |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |                     | (X3) DATE SURVEY<br>COMPLETED  |             |                           |
|--|--|---|---------------------|--|-------------|---------------------------|
|  |  | 495045  | B. WING             |  | 03/04       | /2015                     |
|  | PROVIDER OR SUPPLIER<br>CARE HEALTH SERVI  | CES-STRATFORD HALL REVIS  | en                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228  |             |                           |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDERS PLAN OF CORRECTK<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | DBE C       | (X5)<br>OMPLETION<br>DATE |
| F 431  | Continued From pa<br>be readily detected.  This REQUIREMEN   | _   | F 431               | Criteria 1 Incident report completed for Reside MD notified with no new orders.  Resident #20 received her medicatio ordered.  |             |                           |
| `  | by: Based on observati document review, it facility staff failed to nursing units (the 60 LPN (licensed pract on top of the medica   | ion, staff interview, and facility was determined that the secure medications on 1 of 5 00 unit).  Ical nurse) #2 left medications atton cart and the cart medication   |                     | LPN#2 educated on not leaving medications unsupervised and on not leaving medication cart unlocked du medication administration to ensure safety of Residents #27 and #28.  Criteria 2 All residents have the potential to be affected.  | ring<br>the | -                         |
|  | the 600 nursing unit administration obser was observed in the drawers/front side fa hallway. The cart was inverted drinking cup Under this cup were "hydrocodone 7.5 mg pain medication), "po (milliequivalents) (us replacement), and "h treat high blood pressfor Resident #20).  On 3/3/15 at 5:07 p.m services) walked by the drawer that was slight | m., the surveyor arrived on for the medication vation. A medication cart hallway, against the wail, the cing out towards the open as observed unlocked. An was on top of the cart. the following medications: g. (milligrams) (a narcotic otassium 20 meq ed for potassium ydralazine 25 mg. (used to sure) (the medications were |                     | Nurses have been reeducated on not leaving medications unsupervised at not leaving medication cart unlocked while unattended.  Criteria 3 LPN #2 on not leaving medications unsupervised and on not leaving medication cart unlocked while unattended.  Reeducate the nursing staff on not leaving medications unsupervised and on not leaving medications unsupervised and on not leaving medication cart unlocked when unattended. | eaving      |                           |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING                       |   |                            | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|--|--|---|----------------------------|-------------------------------|--|
|  |   | 495045   | B. WING  |   | 03                         | 3/04/2015                     |  |
|  |   | ICES-STRATFORD HALL REVIS  | ED   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228   |                            |                               |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE |   | (X5)<br>COMPLETION<br>DATE |                               |  |
|  | At this time (5:11 p. down the hall to the turning the cart so t resident's room, in the fact that was observed properties at the way with his use a key to unlock was not locked. LP medications for ano The inverted drinking remained on top of the inverted drinking cup. When medications were for Resident #20)." At the following medication in the inverted drinking up to and "Miralax (a hear constipation). He the Tylenol (used to treat constipation) are the resinverted drinking up to (now having 2 inverted drinking up to and #19), and left the unlocked to obtain the This was approximate approximately 5:23 p | In., LPN #2 (Licensed returned to the cart.  In.), LPN #2 moved the cart room of Resident #19, he drawers faced towards the he doorway of the room. LPN illing the lock on the cart out hand, and did not attempt to the cart, indicating the cart N #2 was observed preparing ther resident (Resident #19). In group containing medications the cart. He picked the cup clearly revealed that a aining pills was under the asked what resident the r, he stated, "(name of his time, he prepared the s for Resident #19: used to treat neuropathy), and to treat GERD), inarcotic pain medication), ping cap full) (used to treat en searched the cart for at pain) and was not able to sident. He then placed an over the cup of medications, and drinking cups covering if the cart - for Resident #20 a cart unsupervised and a Tylenol from the stat box. | F 431  | Criteria 4 ADNS/designee will randomly audit medication administration weekly x weeks and monthly x2 months and r to QAA committee for review and recommendations.  Criteria 5 The facilities alleged date of complia April 18, 2015. | 4<br>eport                 |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |                   |  | (X3) DATE SURVEY<br>COMPLETED     |                            |
|--|--|---|-------------------|--|-----------------------------------|----------------------------|
|  |  | 495045  | B. WING           |  | ο.                                | 3/04/2015                  |
|  | F PROVIDER OR SUPPLIER<br>RCARE HEALTH SERV  | ICES-STRATFORD HALL REVIS   | ED.               | STREET ADDRESS, CITY, STATE,<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |                                   |                            |
| (X4) IC<br>PREFD<br>TAG  | ( EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | IX (EACH CORRECTIVE AC   | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 43   | After administering LPN #2 was observed them moved the car Resident #28 (approplaced the medicati Resident #28, the conference of the following #28: "aspirin 81 mg" "Tylenol 650 mg, and vitamin deficiency). The medication cart (used to replace cal administer the resid it. He then left the comedication room for 5:30 p.m LPN #2 unsupervised. He may be approximately 5:36 on 3/4/16 at 3:08 p. conducted with LPN nervous about being have left meds (medications were unthe surveyor initially LPN #2 was not presided in the facility and the facility and the facility and the facility and the facility and the facility and the facility and facil | medications to Resident #19, red placing the medications for the medication cart. LPN #2 t down to the room for eximately 5:26 p.m.). LPN #2 on cart in front of the room for art was positioned in the the resident's room. He then ing medications for Resident (used to prevent blood clots), at **Thera M multivitamin (for He was observed searching for *caltrate with Vitamin D cium and vitamin D) to ent but was unable to locate art again, to search the caltrate at approximately eft the cart unlocked and eturned to the cart at p.m.  **Thera M multivitamin D to ent but was unable to locate art again, to search the caltrate at approximately eft the cart unlocked and eturned to the cart at p.m.  **Thera M multivitamin D to ent but was unable to locate art again, to search the caltrate at approximately eft the cart unlocked and eturned to the cart at p.m.  **Thera M multivitamin D to ent but was unlocked and seurned to the cart at p.m. | F                 | 431  |                                   |                            |
|  | Administration Guide<br>"Medications and b   | dication and Treatment<br>lines" documented,<br>iologicals are securely   |                   |  |                                   |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |             | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|--|--|-------------|-------------------------------|--|
|   |   | 495045   | B. WING                                |  | 03          | /04/2015                      |  |
|   | ·   | ICES-STRATFORD HALL REVI   | SED 21:                                | REET ADDRESS, CITY, STATE, ZIP (<br>25 HILLIARD ROAD<br>CHMOND, VA 23228                   | CODE        |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
|   | and maintained und actively utilized and for medication admit for medication admit for medication admit actively utilized and for medication admit and Assistant Direct aware of the finding provided by the end Resident #20 was a 2/15/08 with the diagleg amputation, high osteoporosis, and comost recent MDS (Mannual assessment Reference Date) of a coded as being cogridally life decisions. The requiring limited assistance for transtructure was actively 1/19/14 with the diagraphic and supervision Resident #27 was actively 1/19/14 with the diagraphic and supervision Resident #19 was admitted assistance for bathing the second material supervision Resident #19 was admitted assistance, high blood possible places, high blood possible places, high blood possible places. | anly to licensed nursing staff for a lock system when not attended to by nursing staff inistration"  I.m., the Director of Nursing for of Nursing were made s. No further information was of the survey.  I.m. the Director of Nursing for of Nursing were made s. No further information was of the survey.  I.m. the Director of Nursing for of Nursing were made s. No further information was of the survey.  I.m. the Director of Nursing for of Nursing were made so the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the provided the survey.  I.m. the Director of Nursing was of the provided the survey.  I.m. the Director of Nursing was of the provided the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Director of Nursing was of the survey.  I.m. the Dir | F 431                                  |  |             |                               |  |

|   | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |         |  | (X3) DATE SURVEY<br>COMPLETED             |           |
|---|--|--|---|---------|--|---|-----------|
|   |  |  | 495045  | B. WING |  |   | 3/04/2015 |
| NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-STRATFORD HALL REVISE |  |  |   |         | TREET ADDRESS, CITY, STATE, ZIP CODE<br>125 HILLIARD ROAD<br>ICHMOND, VA 23228                         | <u> </u>                                  | 3/04/2019 |
|   | (X4) ID<br>PREFIX<br>TAG   | IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |   |         | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | ON SHOULD BE COMPLE<br>E APPROPRIATE DATE |           |
|   | A eas  | was coded as cognitively life decisions; extensive assistant dressing, and transleating.  Resident #28 was a 12/18/13 with the dinigh blood pressure and deep vein thron was an annual asset 12/27/14. The reside cognitively impaired decisions; and was assistance for translassistance for bed in hygiene; and supervious According to "Fundaledition, 2009: Patriciperry: Mosby, Inc; Perry: Mosby, Inc; Perry: Mosby, Inc; Perry: Medications are in inceptional and Practice, 4th ed. Inc., page 376, by Positifin Perry: "Medication, 2001: Patricipe left unattended, and been decording to Fundamental dition, 2001: Patriciperry; Mosby, Inc., page 376, by Positifin Perry: "Medication, 2001: Patriciperry; Mosby, Inc., page 376, | aitively intact in ability to make and was coded as requiring the for bathing, hyglene, fers; and limited assistance for admitted to the facility on agnoses of but not limited to a arthritis, thromboembolus, mbosis. The most recent MDS assment with an ARD of the lent was coded as severely in ability to make daily life coded as requiring total fers out of bed; extensive mobility, dressing, and rision for eating.  Immentals of Nursing" 7th and Anne Griffin age 703. "Make sure that all backed containers in a room am) or are under constant attorn obtained from ursing: Concepts, Process, St Louis: Mosby-Year Book, atter, Patricia A., and Anne actions of any sort should not and patients should be | F 431   |  |   |           |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---------------------|--|-------------------------------|----------------------------|
|   |   | 495045   | 8. WING_            |  | 03                            | /04/2015                   |
|   | PROVIDER OR SUPPLIER RCARE HEALTH SERV  | ICES-STRATFORD HALL REVIS  | en                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2125 HILLIARD ROAD<br>RICHMOND, VA 23228  |                               | 10-42-013                  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC (DENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP  | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 431   | *Information obtain   | ege 62<br>ed from Nurse's Drug Guide<br>, pages 9, 222, 593, 698, 752,   | F 431               |  |                               |                            |
|   | 755, 1152, and 125  **Information obtain http://www.nlm.nih., s/a603032.html                      | 9 ned from gov/medlineplus/druginfo/med ned from   |                     |  | Au                            |                            |
| F 514<br>SS=D   | s-8274.htm<br>483.75(I)(1) RES  | cyhealth.net/d/thera-m-vitamin   | F 514               | It is the intended practice of this facilit<br>maintain clinical records on each resid   | lent                          | 04/18/15                   |
| -   | resident in accordar<br>standards and pract   | nintain clinical records on each<br>nce with accepted professional<br>ices that are complete;<br>ted; readily accessible; and<br>lized.        |                     | in accordance with accepted profession<br>standards and practices that are comple<br>accurately documented; readily access<br>and systematically organized.  It is also the intended practice of this  | ete;                          |                            |
|   | information to identification resident's assessme services provided; the                          | nust contain sufficient<br>by the resident; a record of the<br>ints; the plan of care and<br>be results of any<br>ning conducted by the State; | ,                   | facility to ensure that the clinical record<br>contain sufficient information to identi<br>the resident; a record of the resident's<br>assessments; the plan of care and service<br>provided; the results of any preadmissis<br>screening conducted by the State; and<br>progress notes. | fy<br>ces                     |                            |
| 7   | by: Based on clinical red and facility document that the facility staff for and accurate clinical | y sample, Residents # 6.   |                     |  |                               |                            |

| 1   |   |  | - WINDOWN OCKAIOEO                                     |          |   | JWG NO                        | ). 0938-039        |
|---|---|--|--|----------|---|-------------------------------|--------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ,        | PLE CONSTRUCTION<br>G                         | (X3) DATE SURVEY<br>COMPLETED |                    |
| Į.  |   |  | 495045   | B. WING_ |   | 03                            | /04/2015           |
| ĺ   | NAME OF   | PROVIDER OR SUPPLIER   |  |          | STREET ADDRESS, CITY, STATE, ZIP CODE         |                               |                    |
| l   | MANOR   | ****   |  |          | 2125 HILLIARD ROAD                            |                               |                    |
| ۱   | MANOR   | CARE HEALIN SERVI  | ICES-STRATFORD HALL REVIS                              | SED      | RICHMOND, VA 23228                            |                               |                    |
| ľ   | (X4) IO   | SUMMARY STA  | TEMENT OF DEFICIENCIES                                 | ID       | PROVIDER'S PLAN OF CORRECTION                 | )M                            | 775                |
| ŀ   | PREFIX  | (EACH DEFICIENCY   | / MUST BE PRECEDED BY FULL                             | PREFIX   | (EACH CORRECTIVE ACTION SHOUL                 | DBE                           | (X5)<br>COMPLETION |
|   | TAG   | REGULATORY OR L  | SC (DENTIFYING INFORMATION)                            | TAG      | CROSS-REFERENCED TO THE APPROL<br>DEFICIENCY) | PRIATE                        | CATE               |
| f   |   |  |  | 1        |   |                               | 1                  |
|   | F 514   | Continued From page  | ge 63  | F 514    | Criteria 1                                    |                               |                    |
|   |   | document with anot   | her resident's name.                                   | }        | Resident #6 clinical record was corr          | ected                         |                    |
|   |   |  |  |          | and lab was placed into correct resid         |                               | 1                  |
|   |   | The findings include   | <b>э</b> :   |          | clinical record.                              | ICHT 2                        |                    |
|   |   | D14440   |  |          |   |                               | }                  |
|   |   | Resident # 6 was admitted to the facility on 6/12/09 and readmitted on 1/7/13 with diagnoses |  |          | Criteria 2                                    | ļ                             |                    |
|   |   | o/ 12/09 and readmit   | tted on 1///13 with diagnoses                          |          | All residents have the potential to be        | !                             |                    |
|   | į   |  | re not limited to: Alzheimer's                         | i        | affected.                                     |                               |                    |
|   | disease, diabetes, atrial fibrillation, depression, macular degeneration, anxiety, gastroesophageai |  |  |          |   |                               |                    |
|   | ŀ   | reflux disease, chronic obstructive pulmonary  |  |          | Review all lab sections of all resider        |                               |                    |
|   | -   | disease, and osteoa  |  |          | ensure complete and accurate clinica          | d                             |                    |
|   | ļ   |  |  |          | records.                                      |                               |                    |
|   | [   | Resident # 6's most  | recent MDS (minimum data                               |          | Cuitanita a                                   | j                             |                    |
|   |   | set) was an annuai a   | assessment, with an ARD                                |          | Criteria 3  Nursing and medical record staff  | i                             |                    |
|   | 1   | (assessment referen  | ice date) of 1/16/15. The                              |          | reeducation on need to check resider          |                               |                    |
|   |   | Resident was coded   | as being usually understood                            |          | charts to ensure correct information          |                               |                    |
|   | ļ   | oy others and as son   | netimes understanding                                  |          | placed in correct resident records.           | .s                            | ,                  |
|   | ]   | outers. The resident   | t was cognitively impaired,<br>possible 15 on the BIMS |          | placed in correct resident records.           | - 1                           |                    |
|   |   | (Brief Interview for M   | leptel Status) even                                    |          | Criteria 4                                    |                               |                    |
|   |   | (Dires intellegeness for its   | ieriai Status) exam.                                   |          | ADNS/designee will randomly audit             | ľ                             |                    |
|   |   | During a clinical reco   | ord review another resident's                          |          | resident clinical records to ensure pro       | mar                           |                    |
|   | 1   | aboratory report was   | observed in Resident # 6's                             |          | labs are on proper chart weekly x4 w          | eeke                          | i                  |
|   |   | record.  |  |          | and monthly x2 months and report to           | COAA                          | 1                  |
|   | 1   |  | 1  |          | committee for review and                      | YAAA                          | ļ                  |
|   | [1  | During an interview o  | n 3/4/15 at 10:05 a.m. with                            |          | recommendations.                              | 1                             |                    |
|   |   | PN (licensed practic   | al nurse) # 4 this finding                             |          |   | 1                             | i                  |
|   | [1  | was confirmed. Whe   | n LPN # 4 was asked who                                |          | Criteria 5                                    |                               | 1                  |
|   | (   | loes the filing of labo  | ratory reports LPN #4                                  |          | The facilities alleged date of complia        | nce is                        | l                  |
|   |   | stated that it varies. \   | When the reports are                                   |          | April 18, 2015.                               | 100 13                        | 1                  |
|   | r   | eceived the nurse far  | xes a copy to the physician                            |          |   | - 1                           | ]                  |
|   | } <b>€</b>  | ind then files a copy  | in the resident's chart.                               | -        |   |                               |                    |
|   |   | During an interview or   | n 3/4/15 at 10:10 a.m. with                            | ļ        |   |                               | İ                  |
|   | Ī   | SM (administrative s   | staff member) # 2, the                                 | }        |   |                               | 1                  |
|   | d   | irector of nurses, this  | s finding was revealed. A                              | ٠. ا     |   |                               |                    |
|   | r   | equest was made for  | the facility policy at this                            | j        |   | 1                             | ]                  |
|   | ļ ti  | me,  |  |          |   |                               | ſ                  |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLI<br>A. BUILDING | CONSTRUCTION   | (X3) DA                      | TE SURVEY<br>MPLETED       |
|--------------------------|--|---|------------------------------|--|------------------------------|----------------------------|
|                          |  | 495045  | B. WING                      |  | 03                           | /04/2015                   |
|                          | <del>,</del>   | VICES-STRATFORD HALL REVIS  | SED 21                       | REET ADDRESS, CITY, STATE, ZIP<br>25 HILLIARD ROAD<br>CHMOND, VA 23228                     | CODE                         |                            |
| (X4) ID<br>PREFIX<br>TAG | i (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|                          | On 3/4/15 at 10:50 policy was present member) # 4, med During an interview ASM # 1, the adminisfiled laboratory  The facility's policy GUIDELINES FOF CONTENT: A clinic confidential medical sufficient data to id diagnosis and treat reflect the condition stay in the center fromplete record confidential represent of the patient in the interdisciplinary applanning and care of record documentation the quality assessment of the patient information the survey.  Potter-Perry Fundamental fedition, page 477 reanything written or precord or proof for a Documentation with aspect of nursing production in the patient in mustand flexible enough maintain continuity of page 470 reanything written or precord or proof for a Documentation mustand flexible enough maintain continuity of the page 475 reanything written or precord or proof for a Documentation mustand flexible enough maintain continuity of the page 475 reanything written or procumentation mustand flexible enough maintain continuity of the page 475 reanything written or procumentation mustand flexible enough maintain continuity of the page 475 reanything written or procumentation mustand flexible enough maintain continuity of the page 475 reanything written or procumentation mustand flexible enough maintain continuity of the page 475 reanything written or procumentation mustand flexible enough maintain continuity of the page 475 reanything written or procumentation mustand flexible enough maintain continuity of the page 475 reanything written or procumentation mustand flexible enough maintain continuity of the page 475 reanything written or procumentation mustand flexible enough maintain continuity of the page 475 reanything written or procumentation with the page 475 reanything written or procumentation with the page 475 reanything written or procumentation with the page 475 reanything written or procumentation with the page 475 reanything written or procumentation with the page 475 reanything written or procumentation with the page 475 reanything written or procumenta | a.m. a copy of the facility ted by OSM (other staff lical records staff.  of on 3/4/15 at 11:00 a.m. with inistrator, this finding of the report was revealed.  "REQUIREMENT'S AND RECURD cal record is compiled as a sel legal document containing tentify the patient, justify the patient, justify the patient throughout the rom admission to discharge. A contains an accurate and station of the actual experience center and reflects an acroach to assessment, care delivery. Review of clinical on is an important aspect of tent and assurance process."  on was provided by the end of mentals of Nursing, 6th eads: "Documentation is printed that is relied on as authorized persons.  in a client record is a vital | F 514                        |  |                              |                            |

| STATEMEN<br>AND PLAN     | IT OF DEFICIENCIES<br>OF CORRECTION   | CORRECTION IDENTIFICATION NUMBER:   |                                       | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING  |                                 |                            |  |
|--------------------------|---|---|---------------------------------------|---|---------------------------------|----------------------------|--|
|                          |   |   |                                       |   |                                 |                            |  |
|                          |   | /ICES-STRATFORD HALL REVI:  | STREET ADDRESS, CITY, STATE, ZIP CODE |   |                                 |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                   | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO TO<br>DEFICIENCY | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |  |
| 1                        | According to Funda Incredibly Easy, Lip Philadelphia PA, pa documentation is a documentation is a nursing care. Patie and need to be according to that care can be conhealth care team. Undocumentation provipatient and family opossible. Many nursithey document or face enormous effect on | amentals of Nursing Made  | F 514                                 |   |                                 |                            |  |