PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495045	B. WING			C <b>02/15/2017</b>
NAME OF I	PROVIDER OR SUPPLIER		L	s	TREET ADDRESS, CITY, STATE, ZIP CODE	OZ/10/Z011
				2′	125 HILLIARD ROAD	
MANOR	CARE HEALTH SERVI	CES-RICHMOND		R	ICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
			<del></del>	ŀ	The statements made on this plan	3/31/17
F 000	INITIAL COMMENT	rs	F	000	of correction are not an admission	
					to and do not constitute an	•
	An unannounced Medicare/Medicaid standard				•	
		ted 2/14/17 through 2/15/17.			agreement with the alleged	
		vestigated during this survey.			deficiencies cited herein.	•
		uired for compliance with the			m 11	
		art 483 Federal Long Term	-		To remain in compliance with all	
		The Life Safety Code			federal and state regulations, the	
	survey/report will fo	llow.			center has taken or will take the	
	The concue in this	194 certified bed facility was			actions set forth in the following	•
		ne survey. The survey sample	:		plan of correction. The following	
÷		rent residents reviews	:		plan of correction constitutes the	
	(Residents #1 throu	gh #22, and #26 through			center's allegation of compliance.	
	#29), and 3 closed	record reviews (Residents #23			All alleged deficiencies cited have	;
	through #25).		•		been or will be corrected by the	
		I)(5)(13)(16)-(18) NOTICE OF SERVICES, CHARGES	F	156	date or dates indicated.	3/31/17
		ust ensure that each resident				
		f the name, specialty, and way			*	
		ysician and other primary care			T 156	
	professionals respo	nsible for his or her care.	***		F-156	
	(1) The resident has his or her rights and	tion and Communication. s the right to be informed of I of all rules and regulations			It is the intent of this facility to inform the resident both orally an in writing in a language that the	d
	during his or her sta	conduct and responsibilities by in the facility.			resident understands of his/her rights and all rules and	
	(g)(4) The resident	has the right to receive			regulations governing resident	
		ning spoken) and in writing			conduct and responsibilities	
		a format and a language he			during the stay in the facility.	
	or she understands	, including:				
	(i) Required notices as specified in this section. The facility must furnish to each resident a written				RECEIVED	
	description of legal	rights which includes -			MAR 0 9 2017	
ADODATODY	AIDECTARIS OF PRAVIO	EDISLIDDLIER REPRESENTATIVE'S SIGN	JATLIDE		VDH/GI-C	(Y6) DATE

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

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

Event ID: ODYV11

Facility ID: VA0241

		AND HÜMAN SERVICES  & MEDICAID SERVICES				F	NTED: 02/28/2011 FORM APPROVED B NO. 0938-0391			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(×	(3) DATE SURVEY COMPLETED			
		495045	B. WING				C <b>02/15/2017</b>			
	PROVIDER OR SUPPLIER  CARE HEALTH SERV	ICES-RICHMOND		212	REET ADDRESS, CITY, STATE, ZIP CODE S HILLIARD ROAD CHMOND, VA 23228					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE				
F 156		~	F 1	56	Also, it is the intent of this fact to provide each resident with	the	3/31/17			
	(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;		***		* <u>}</u> %-		notice of the State develope under1919(e)(6) of the act. I the intent of this facility that s	t is	is -	
		the requirements and blishing eligibility for Medicaid,			notification be made prior to upon admission and during t	or				

- including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and
- email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and
- (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
- (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older

upon admission and during the resident's stay. Receipt of such information, and an amendments to it, must be acknowledged in writing.

#### Criteria 1

Upon notification from surveyor resident #18 was signed but late. Resident #1 was signed but late. Resident #3 was signed but late. Resident #21 was signed but late. Resident #23 was signed but late.

#### Criteria 2

Any and all residents have the potential to be affected.

#### Criteria 3

The admission team will be reeducated on need to inform all residents and their responsible parties of their rights, rules and regulations governing their conduct and responsibilities during their stay in the facility within two business days of admission.

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

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 2 of 134

RECEIVED

MAR 0 9 2017



PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED
		495045	B. WING			C 0 <b>2/15/201</b> 7
NAME OF F	PROVIDER OR SUPPLIER	And the second s		STREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	ICES-RICHMOND	***************************************	2125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ULD BE	(X5) COMPLETION DATE
						3/31/17
F 156	Continued From page	ige 2	F 1	156 Critorio 4		
		965, as amended 2016 (42		<u>Criteria 4</u>	i .	
Í		) and the protection and	•	Administrator or designee wil		
		as designated by the state, and	; •	audit admission contracts dail	y .	
		er the Developmental nce and Bill of Rights Act of		x5days, three days weekly x3	•	
	2000 (42 U.S.C. 150			weeks, and monthly x2 month	ıS.	
		ill be implemented beginning		Criteria 5		
	November 28, 2017					
ı				The facility's alleged date of compliance is 3/31/2017.		:
ı		arding Medicare and Medicaid		compliance is 3/31/2017.		
!	eligibility and covera		•			
	[§483.10(g)(4)(iii) wi November 28, 2017	vill be implemented beginning 7 (Phase 2)]				
	Disability Resource Section 202(a)(20)(I Act); or other No Wi	ation for the Aging and Center (established under (B)(iii) of the Older Americans frong Door Program; vill be implemented beginning 7 (Phase 2)]				
	Control Unit; and	tion for the Medicaid Fraud ill be implemented beginning 7 (Phase 2)]				
	grievances or compl suspected violation of facility regulations, in resident abuse, negli misappropriation of facility, non-compliant directives requirement	contact information for filing plaints concerning any of state or federal nursing including but not limited to glect, exploitation, resident property in the ance with the advance ents and requests for ng returning to the community.				

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

(g)(5) The facility must post, in a form and manner accessible and understandable to

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 3 of 134

RECEIVED

MAR 0 9 201?

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495045	(X2) MULT A. BUILDI B. WING		(X3) DATE SURVEY COMPLETED C 02/15/2017
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERV			STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION

#### F 156 Continued From page 3

residents, resident representatives:

- (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and
- (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.
- (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.
- (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.
- (i) The facility must inform the resident both orally and in writing in a language that the resident

F 156

DEPARTMENT OF HEALTH AND H	DWAN SERVICES
CENTERS FOR MEDICARE & MED	ICAID SERVICES

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	13 FOR MEDICARE	& MEDICAID SERVICES				OIVI	B NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	TIPLE CONSTRUC	CTION	0	X3) DATE SURVEY COMPLETED
		495045	B. WING				C <b>02/15/2017</b>
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STATE, ZIP CO	DE	
MANOR	CARE HEALTH SERVI	CES-RICHMOND		2125 HILLIAR RICHMOND			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EAC	ROVIDER'S PLAN OF CORI CH CORRECTIVE ACTION S S-REFERENCED TO THE A DEFICIENCY)	SHOULD B	
F 156	Continued From pa	ge 4	F	156			,
	understands of his regulations governing	or her rights and all rules and ng resident conduct and ng the stay in the facility.					
		also provide the resident with dinotice of Medicaid rights and					
		information, and any nust be acknowledged in					
	(g)(17) The facility r	nust					
	writing, at the time of	icaid-eligible resident, in of admission to the nursing e resident becomes eligible for			-		
	nursing facility servi	ervices that are included in ces under the State plan and nt may not be charged;	ŧ				
	facility offers and for	ns and services that the r which the resident may be nount of charges for those					
	changes are made t	licaid-eligible resident when to the items and services phs (g)(17)(i)(A) and (B) of					
	before, or at the time periodically during the available in the facili	nust inform each resident e of admission, and ne resident's stay, of services ity and of charges for those any charges for services not					The state of the s

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

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 5 of 134



MAR 0 9 2017



DEPARTMENT OF HE	ALTH AND	HŮAN	SERVICES
CENTERS FOR MEDIC	CARE & ME	EDICAID	SERVICES

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495045	B. WING	<b>3</b>		C 02/15/2017
NAME OF F	PROVIDER OR SUPPLIER		I	П	STREET ADDRESS, CITY, STATE, ZIP CODE	
MANORO	NADE WEALTH CEDVI	ree bicusoun		:	2125 HILLIARD ROAD	
WANORC	CARE HEALTH SERVI	CES-RICHINOND			RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	(TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΉX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 156	Continued From pa	ae 5	· F	156	, 6	
	= <del>-</del>	licare/ Medicaid or by the				
	and services covered Medicaid State plan notice to residents or reasonably possible (ii) Where changes items and services facility must inform 60 days prior to imperent the facility must refund representative, or edeposit or charges apper diem rate, for the	are made to charges for other that the facility offers, the the resident in writing at least plementation of the change.  Is or is hospitalized or is as not return to the facility, the to the resident, resident estate, as applicable, any already paid, less the facility's ne days the resident actually				
	facility, regardless of discharge notice re-					
	resident representa	at refund to the resident or attive any and all refunds due 30 days from the resident's from the facility.				
	behalf of an individu facility must not cor these regulations.	admission contract by or on ual seeking admission to the offict with the requirements of				

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

Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to inform five of 29 sampled

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 6 of 134

RECEIVED

MAR 0 9 2017



:					PRINTE	): 02/28/2017
		AND HUAN SERVICES  & MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495045	B. WING_		02	C / <b>15/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
MANORO	CARE HEALTH SERVI	CES-RICHMOND		2125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 156	Continued From pa	~	F 1	<b>56</b> .		
	#1, Resident #3 and admission of their r	at #23, Resident #18, Resident d Resident #21), at the time of ights, and the rules and their ng their stay at the facility.	·			
	8/3/16 and was not sign an admission of	as admitted to the facility on presented with, and did not contract, which explained care the expenses for such care,				
	the resident and RF rights, rules, and re	B, facility staff failed to inform (responsible party) of her sponsibilities of her stay at the he was admitted on 7/20/16.				,
	10/21/16. The residence containing consent responsibilities, responsible party respo	admitted to the facility on dent's admission agreement for treatment, facility ident responsibilities and esponsibilities was not signed sponsible party until 11/18/16.				
	agreement containi facility responsibiliti	the resident's admission ng consent for treatment, es, resident responsibilities rty responsibilities was not s after admission.				
	the resident and RF rights, rules, and re	I, facility staff falled to inform (responsible party) of her sponsibilities of her stay at the				

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

The findings include:

1. Resident #23 was admitted to the facility on 8/3/16 and was not presented with, and did not

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 7 of 134



MAR 09 201?



### DEPARTMENT OF HEALTH AND HOMAN SERVICES

PRINTED: 02/28/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES				<u>omb no.</u>	<u>. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		PLE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		495045	B. WING	·		1	C 15/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERV	ICES-RICHMOND		1	2125 HILLIARD ROAD		
<del></del>					RICHMOND, VA 23228		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 156	Continued From pa	age 7	, F	156	· 6		
	sign an admission of	contract, which explained care the expenses for such care,					
	8/3/16 with diagnos limited to; a heart a	admitted to the facility on ses that included, but were not attack, back pain, peripheral diabetes and difficulty walking.	.•				
	set) was a quarterly (assessment refere Resident #23 was of BIMS (brief intervier 13 out of 15. The Finstrument) manual	st recent MDS (minimum data y assessment with an ARD ence date) of 11/9/16. coded on the MDS as having a ew for mental status) score of RAI (resident assessment I documents that a score of 13 esident's cognition is intact.					
	revealed, in part, the provided with an ad of admission from the The admission agree #23 and facility staff member) #12, the b	nt #23's clinical record hat Resident #23 was not almission agreement at the time the hospital into the facility, element signed by Resident ff member OSM (other staff business development hed on 10/26/16 and included mentation;	:				
	Patient and Center" "Your Signature is F Name ('Patient' or 'I name) Responsible Party N Resident #23 entere Your Admission Agn	Required Resident'): (Resident #23's  Name (if applicable): (Name of			RECEIVED  MAR 0 9 2017  VDH/OLC		

Signature of Patient or Responsible Party:

facility)

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495045	B. WING			l .	C / <b>15/2017</b>
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CO 2125 HILLIARD ROAD RICHMOND, VA 23228	DDE	<u> </u>	10/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
F 156	We have summar Admission Agreen page. For comple entire Agreement. document and the Information Handle agree to the terms acknowledge that materials indicated 4 Key Items:  1. Consent (Secticallow us to treat your Responsible are required to:  "Provide care and Notify you of our Refund any ard Resident's Responsible are required in Pay us for our Notify us of charman and the payment directly frogovernment payer 4. Responsible Pader 1, Page 3) - Your manufacturer your the Patient pay for the Patient	ident #23). Date: 10/26/16. rized the key provisions of the ment ('Agreement') on this first ate information, please read the . This Agreement includes this a center Supplement and Patient book. By signing above, you is of the Agreement and you you have received the dibelow.  on 1; Page 2) - You consent to ou to maintain your well-being. ilities (Section 2; Page 2) - We and services to you. pur rates. mounts owed to you. ponsibilities (Section 3; Page 2) to: r services. nanges in your health coverage. right to bill and receive rom your insurance or r. arty's Responsibilities (Section responsible party is required to: nt's income and resources to t's stay. th us to secure payment from	TAXABLE PRODUCTION OF THE PRODUCTION OF T	156			
*	Patient Information Supplement- Thes services, including "Resident Righ "Notice of Infor "Medicare and	n Handbook and Center se items describe many of our g but not limited to:		RECEIVED  MAR 0 9 2017  VDH/OLC			

Other Documents that require your signature: Receipt of Notice of Information Practices

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR M	<b>EDICARE</b>	E & MEDICAID SERVICES			OMB N	O. 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Į.	TIPLE CONSTRUCTION ING	(X3) D.	ATE SURVEY OMPLETED
	:	495045	B. WING		0	C 2/15/2017
NAME OF PROVIDER OF		ICES-RICHMOND		STREET ADDRESS, CITY, STATE, ZIP 2125 HILLIARD ROAD RICHMOND, VA 23228		
PREFIX (EACH	DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
" Skilled applicable " Sex C " Volunt If you have please connumber)  [PAGE TV 1. CONSE You conse A. Use an purposes operations B. Treat you C. Photog 2. CENTE We will:  A. Provide facilities, higher al nu social serving request, diadministra	dent Trust d Nursing e Offender R tary Arbitrate question intact our A NO Service of treatments ou to main praph you in the course of treatments ou to main praph you with the coursing carrovices, and direction arative and control of the course of treatments ou to main praph you with the course of treatments out to main praph you with the course of treatments out to main praph you with the course of treatments out to main praph you with the course of the course	Fund Authorization pracility Determination, if Registry Notice ration Agreement, if elected ns about this Agreement, Administrator at (phone	F 1:			
two month C. Refund days or wit law after y	our deposes of your self any amount thin the tire our discharge ENT'S RES	sit, if any, to your first one or stay at the Center. ounts owed to you within 30 me frame required by state arge or transfer. SPONSIBILITIES		RECEIVED MAR 0 9 2017	•	

1. The room and board rate for all days that you

reside at the Center including the day of admission. Unless you are covered under

ADH/CTC

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CEIVICE	19 LOV MEDICAVE	A MEDICAID SERVICES			OMO IA	O. 0330-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILL	LTIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED
		40.004.00	D WING			С
		495045 .	B. WING	The state of the s	0	2/15/2017
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-RICHMOND		STREET ADDRESS, CITY, STATE, ZIP COD 2125 HILLIARD ROAD RICHMOND, VA 23228	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE
F 156	may bill you for a la Center before 12:00 discharge. The late accrued by you whip p.m. on the day of you have room and board writing 30 days before Board Rates are listed Supplement).  2. All additional and while in the Center. described in the Center described in the Center. described in the Center described in the Center sort in the Centers for Medicaid, or Vetera 4. Any additional or covered by your instituted party payer.  5. Within 30 days or hire a collection age payment on your accollection costs.  B. Pay other provide physician, directly for your insurance plans or go. Notify us within your directly from your in you authorize the Cother information to the Centers for Medicaid.	trance plan that prohibits it, we te fee if you do not leave the D p.m. on the day of your efee will reflect any charges le in the Center after 12:00 your discharge. If we change I rate, we will notify you in ore the change. (Room and ted in the Center dillary charges accrued by you (Ancillary charges are enter Supplement).  It is, deductibles or receive for non-covered eligible for any insurance or ram including Medicare, n's Administration. denied charges that are not urance company's benefit or if the date on the bill. If we ency or attorney to collect ecount, you will pay for these ers, including your attending or care they provide to you. coverage under any government programs. Writing 5 days if your coverage e plans or government while you are at the Center. I ght to bill and receive money is urance or government payer. I enter and holder of medical or release such information to dicare & Medicaid Services		RECEIVED  MAR 0 9 2017		
	•	to third party payers any		VDH/OLC		

and its agents and to third party payers any information needed to determine your benefits

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION		ATE SURVEY OMPLETED	
		495045	B. WING	·			C <b>2/15/2017</b>	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
MANOR	CARE HEALTH SERV	CES-RICHMOND	2125 HILLIARD ROAD RICHMOND, VA 23228					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 156	Continued From pa and our right to rec	•	F	156				
	[PAGE FOUR]							
	company or their proprivately, you will not request.  F. Pay for any dam or property on the CG. Abide by our potential of the CG. Abide by our	licies and procedures. PARTY'S S ss to the Patient's income or er any documents supporting a Center. es that Patient incurs while at Patient's income or liately and in writing if the esources are depleted. d in a timely and proper us by providing information						

RECEIVED

MAR 0 9 2017

ADH/OFC

5. VENUE NOTICE

H. Not misappropriate the Patient's income or resources or use them for the benefit of someone other than the Patient. If you misappropriate the

All claims relating to this agreement, or any past,

present or future admission of the Patient to the Center, including any claim to enforce this

Patient's income or resources you may be personally liable for the payment of all charges.

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495045	B. WING		C 02/15/2017
NAME OF I	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP COD	
******		and Didlines		2125 HILLIARD ROAD	
MANORO	CARE HEALTH SERV	ICES-RICHMOND		RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE COMPLETION
	care and treatment brought in the Cour where the Center is Venue Notice section filing a complaint with appropriate governing seeking allowable in involuntarily discharyou agree to the Vowhich is a separate Agreement, the Voliwill control. If, howed Agreement is not sit any reason, this Verilla you do not agree please initial here:  6. PHYSICIANS Physicians providing are not employees, the Center but are in practitioners who has Center to care and in the Center to care and in the Center to the Center to the Center to the Center discharged from the Center	claim relating in any way to the provided to the Patient, will be to fithe County and State located. Nothing in this on prevents the Patient from the Center or an mental agency or from eview of any decision to trige or transfer the Patient. If luntary Arbitration Agreement, agreement from this untary Arbitration Agreement ever the Voluntary Arbitration agreement ever the Voluntary Arbitration gned or it is not enforced for the Notice section will control to this Venue Notice section, (blank)  If g services to you at the Center agents, or apparent agents of independent medical ave been permitted to use the treat you.  If MINATION  If gins on the day you are the center unless you are the Center unless you are the Center unless you are 5 days of your discharge date. The center will agreement will section.	F 1	RECEIVED	
	7.2 Termination			MAR 0 9 2017	

You may terminate this Agreement:

A. By you:

VDH/OLC

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR ME	DICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	HES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION		ATE SURVEY OMPLETED
	,	495045	B. WING			0:	C 2/15/2017
NAME OF PROVIDER OR S		<u> </u>		2125	EET ADDRESS, CITY, STATE, ZIP CODE IS HILLIARD ROAD HMOND, VA 23228	<u></u>	110/2011
PREFIX (EACH DI	EFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
of an emerg 2. by provide intent to lead B. By the Control We may terry ou from the Where legal 30 days price cases where individuals in other legal is soon as practice where individuals in other legal is soon as practice and in the safe endangered and and in the safe endangered and in the	ately if your gency; or ding 7 dia ve the Conter: rminate in e Cente ally require the sa in the Coreasons acticable minate the assons; eds cannalth has ger need ety of oth dia in the coreasons acticable minate the assons; eds cannalth has ger need ety of oth dia in the core in	ou leave the Center because or lays written notice of your Center this Agreement and discharge or by notifying you in writing. ired, we will notify you at least our transfer or discharge. In afety or health of you or other enter may be endangered, or if it exist, we will notify you as a before transfer or discharge. The Agreement for any of the not be met in the Center; sufficiently improved so that I our services; her individuals in the Center is her individuals in the Center is enotice, you have failed to pay Center; or erate the Center.  ICE OF INFORMATION  Jume of Resident #23)  Justices which is included in the center is included in the center included		156			

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

religious affiliation (available to clergy only) in the

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 14 of 134



PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

~~!!!	NO FOR MILDIONICE	L & INCOTO NO OFFIANCEO			<u></u>	1410 110	<u>. 0000-009 i</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING			E SURVEY IPLETED
		100045	- Amic				С
		495045	B. WING			02/	15/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
MANOR	CARE HEALTH SERV	/ICES-RICHMOND		2125 HILLIARD ROAD			
2717 14				RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 156	Continued From pa	nga 1/	F 1	1FG			
1 100		<del>-</del>	f i	, <b>30</b>			
	agree agree	object (a check mark by of (name of Resident #23's)					
		to a family member or close					
		cluding clergy, who is involved					
	in my care.	adding diorgy, who is necessary					
	in my series						
	Signed by Resident	t #23, dated 10/26/16					
	Further review of R	Resident #23's clinical record					
	revealed a hospital	discharge summary that					
	contained, in part, t	the following documentation;					
		signs stable), found sitting in					
		Resident #23) in no acute					
		nt) cannot read / write, has					
		ool. Pt will need continuous					
		name of facility) and close (primary care physician)."					
	10110W up with 1 Oi	(primary care physician).					
	The facility was una	able to provide any evidence					
		tract was provided to Resident					
		that the resident was able to					
	understand.						
	A vodevo ef Desides	- Hook to the second					
		nt #23's business file revealed,	1				
		ing on 8/23/17 Resident #23 narges at the facility, these	1				
		the 10% co-payment					
	_	required by Medicare after day					
		eview of Resident #23's					
		provided by the business					
		t Resident #23's outstanding					
		s \$12,892.00. The business	:				
		o provide any evidence that					
	Resident #23 was p	provided information regarding	Í	RECEIVED			
	the change in charç	ges which started on 8/23/16.		and the sections and the sections settlesses			
	The husiness office	e was unable to provide any		MAR 0 9 2017			
		0/26/16 that Resident #23 was		8 880 8 8 4 40 8			
	offered any informati			<b>VDH/OLG</b>			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/28/2017

							MAPPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NC	). 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED C
		495045	B. WING	THE PROPERTY AND THE PR		02	2/15/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		710/2011
				2125 HILLIARD ROAD			
MANOR	CARE HEALTH SERVI	CES-RICHMOND		RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 156	Continued From pa	ge 15	F 1	156			
	requirements and p eligibility for Medica	rocedures for establishing id.					
	approximately 8:30 business office mar describe the process a resident is admitted stated, "We check that and provide a welcome letter was a seed and your listed below." The was asked when the was asked when the application would be OSM #9 stated, "We need and begin the admission, asking the process." OSM #9 who did not have fastated, "We would cresident in need."	anducted on 2/15/17 at a.m. with OSM #9, the ager. OSM #9 was asked to as of the business office when ed to the facility. OSM #9 heir (the resident's) payer type me letter outlining the arance coverage." A copy of was provided and revealed, in ocumentation; "We have age benefits with your estimated responsibility is velcome letter had signature at to indicate receipt and to indicate receipt and the information provided. OSM dent #23 did not have a signed as business office file. OSM #9 to Presented to a resident. The would anticipate Medicaid Medicaid process on the family to help with the was asked about residents mily members, OSM #9 to DSM #9 was asked what a resident who was unable to					

RECEIVED

MAR 0 9 2017

**VDH/OLC** 

read / write and had a low level of

resident to make a mark to witness

comprehension. OSM #9 stated, "If a resident can't read / write then we (the business office)

comprehension." OSM #9 was asked whether or not this process was started for Resident #23.

OSM #9 stated that the first note by the business office occurred on 10/19/16 which stated that

would go over the form in depth and ask the

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED C
		495045	B. WING		02/15/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MANORO	CARE HEALTH SERVI	CES-RICHMOND		2125 HILLIARD ROAD	
				RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFILIENCY)	DBE COMPLETION
F 156	Continued From pa	ge 16	F 1	56	
		ified) from the business office ont #23's room to start the process.			
	conducted with OSI OSM #4 was asked a resident was adm stated that a "welco resident room and t	a.m. an interview was M #4, the admissions director. to describe the process when itted to the facility. OSM #4 me" package was left in the he resident or the responsible			
	agreement. OSM#	ided with an admissions 4 was asked if she ing an admissions agreement			
	to Resident #23. O in admissions at the	SM #4 stated that she was not time of his entry so could not not Resident #23 had been	<u>;</u>		
	provided an admiss				
	conducted with OSM development special describe her role in sign the admission all large filled in to ha admission agreement that she hadn't filled facility) had a back I up." OSM #12 was	is a.m., an interview was M #12, the business alist. OSM #12 was asked to regards to having residents agreement. OSM #12 stated, ave the residents sign the int." OSM #12 further stated in very often but "they" (the og and "needed to get caught asked how she presented the int to the residents. OSM #12			

RECEIVED

MAR 0 9 2017

<u>VDH/OLC</u>

stated, "I hand them the agreement to look over and then ask them to sign it." OSM #12 was asked how she ensured that the residents

understood the agreement. OSM #12 stated that she asked them if they had any questions and if

not then she took their word and their signature

understood. OSM #12 was asked how she was

comprehension or ability to read and / or write.

as affirmation that the agreement was

made aware of a resident's level of

PRINTED: 02/28/2017

DI	EPART	IMENT OF HEALTH	AND HUMAN SERVICES			Mane Comment of the C	FORI	M APPROVED
CI	ENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO	D. 0938-0391
			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
					•			С
1			495045	B. WING			02	2/15/2017
NA	ME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
M	ANOR	CARE HEALTH SERVI	ICES-RICHMOND			125 HILLIARD ROAD ICHMOND, VA 23228		
P	X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>(</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETION DATE
	F 156	Continued From pa	ge 17	, F1	56			
		OSM #12 further st resident say that the OSM #12 was show signed by Resident why the contract wa Resident #23 had be #12 stated, "I was ju further stated that s	at she was not made aware. ated, "I have never had a ey couldn't read a document." which admission agreement #23. OSM #12 was asked as signed on 10/26/16 when been admitted on 8/3/16. OSM ust helping out." OSM #12 she did not know why the ents were not done at the time	The second secon				

On 2/15/17 at 10:45 a.m. an interview was conducted with OSM #13, the rehabilitation director. OSM #13 was asked about Resident #23's ability to comprehend. OSM #13 stated, "Everything had to be simplified and repeated as he (Resident #23) had difficulty understanding. Even the pain scale was a difficult concept for him (Resident #23) and would have to use the visual scale (a series of facial expressions that demonstrated pain free to worst pain ever experienced) to determine whether or not he (Resident #23) was in pain and even then it was a struggle." OSM #13 further stated that the therapy staff had to re-iterate directions a lot in

of the admission. OSM #12 was asked whether or not she was aware that Resident #23 was unable to read or write and had never received any education. OSM #12 stated that she was not aware of that. OSM #12 was asked if she read the entire agreement to Resident #23 word for word. OSM #12 stated that she did not, but she was sure that she would have given a summary of the document. OSM #12 was asked how she verified that Resident #23 understood the agreement. OSM #12 stated, "His signature confirmed that he understood the document. I vaguely remember the resident (Resident #23) but I can't say that I knew he could not read."

RECEIVED

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO	0. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION		TE SURVEY MPLETED
		495045	B. WING	·		1	C / <b>15/2017</b>
NAME OF	PROVIDER OR SUPPLIER		L	ST	REET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
MANOR	CARE HEALTH SERVI	ICES RICHMOND		21	25 HILLIARD ROAD		
MIMIAO	OAKE HEALIH SENVI	CES-MOUROND		RI	ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 156	Continued From pa	ige 18	F ·	156			
: [		mprehension, and information in very simplistic terms.					
	conducted with ASM member) #1, the ad asked what the faci information, such as a resident who coul known to have low of stated, "We would owere alert and orient documents that need the documents and #1 was asked what admission agreement the admission agreement that would be presponsibilities of the stated, "The signature understands and could be asked and the was aware that Fread or write and the was not read to him was not provided the 10/26/16, 84 days a the facility. ASM #1 and he would look in	M (administrative staff dministrator. ASM #1 was illity did differently to provide is the admission agreement, to lid not read or write and was comprehension. ASM #1 communicate orally if they need and explain any eded to be signed, go through explain the contents." ASM explain the contents." ASM the signature on the ent meant. ASM #1 stated that ement was a description of the provided by the facility and the ne resident. ASM #1 further are signifies that the resident onsents to the cost of care and ided." ASM #1 was asked if Resident #23 was unable to eat the admission agreement in word for word and that he admission agreement until after his date of admission to I stated that was a problem into it.					

RECEIVED

MAR 0 9 201?



was conducted with ASM #1, the administrator, and ASM #2, the director of nursing. ASM #1 and

ASM #2 were made aware of the concern that Resident #23 had not been informed of his rights and his financial obligations at the time of his

admission on 8/3/16. Resident #23 had not been provided with an admissions agreement that outlined his rights and responsibilities until

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NO.	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILI		CONSTRUCTION		E SURVEY PLETED
						(	С
		495045	B. WING	<b>3</b>	***************************************	l .	15/2017
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MANOD	CARE HEALTH SERVI	CES DICHMOND		212	25 HILLIARD ROAD		
MIMINON	CARE HEALIH SERVI	CES-RICHMICHD		RIC	CHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	regarding the admis at this time that the balance owed by Rooff.  On 2/15/17 at 5:10 conducted with OSI with ASM #1 in attet to state at what poir was presented to a OSM #4 stated eith admission or when OSM #4 was asked of the admissions a is an agreement for with notification of example the sex off fund account inform agreement." OSM apurpose of the resident signs that are accepting of the to describe the produnable to read or with confirmation that the document and contents.	was requested at this time asion process. ASM #1 stated \$12,892.00 outstanding esident #23 would be written p.m. an interview was M #4, the admissions director indance. OSM #4 was asked intan admissions agreement newly admitted resident. For immediately prior to they arrived at the facility. What to explain the purpose greement. OSM #4 stated, "It treatment and billing along other facility requirements (for iender policy), along with trust lation and voluntary arbitration if was asked to explain the lent signature on the lent. OSM #4 stated, "When the admission agreement they is rules." OSM #4 was asked less for someone who is rite. OSM #4 stated, "The nem. Their signature is ey have understood the lents."		156			
	documentation; "3.	The admission staff					

completes the Financial Information Worksheet in

the Admission Agreement with input from the patient responsible party. (Note - This form must

not be given to the patient / responsible party to complete). The purpose of the Financial

Information Worksheet is to provide information

RECEIVED

MAR 0 9 2017

**VDH/QLC** 

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/28/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO	<u>. 0938-0391</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	TIPLE CO	NSTRUCTION		E SURVEY IPLETED
		495045	B. WING			1	C 15/2017
NAME OF F	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
	and Health offic	iore diculation		2125 I	HILLIARD ROAD		
MANURU	CARE HEALTH SERV	ICES-RICHIMOND		RICH	MOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 156	Continued From pa	age 20	· F1	156			
	•	er selection at admission and					
		for financial counseling with					
		. 4. At admission and in detail	•				
		ice during financial counseling,					
		aware of their legal obligation					
	to pay their estimat	ed private portion amount	:				
	when billed with red	ceipt of funds reasonably					
	assured. 8. The ad	mission staff has a signed and					
	file."	greement with attachments on					·
	No further informat end of the survey p	ion was provided prior to the process.					
	Complaint Deficien	су					
	the resident and RI rights, rules, and re	8, facility staff failed to inform (responsible party) of her esponsibilities of her stay at the was admitted on 7/20/16.					
		admitted to the facility on					
		oses that included but were not					
		abetes, heart failure, atrial					
		e's encephalopathy [1],					
		and dementia with behavioral lent #18's most recent MDS					
		) was a quarterly assessment			•		
		ssment reference date) of					
		#18 was coded as being					
		ely impaired in the ability to					
		ns scoring 09 out of 15 on the					
	BIMS (Brief Interview	ew for Mental Status) exam.		Ø.			
		coded as requiring supervision		R	ECEIVED		
	assistance with dre	and locomotion; limited essing, eating, and personal			MAR 0 9 2017		
		assistance with toileting and on staff with bathing.			WW 0.3 501/		

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

Facility ID: VA0241

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495045	B. WING			02/15/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
MANOR	CARE HEALTH SERV	ICES-RICHMOND		2125 HILLIARD ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	TIX (EACH CORRECTIVE AC	TION SHOULD THE APPROP	BE COMPLÉTION	
F 156	#18's admission ag the business office.  On 2/15/17 at 10:50 conducted with OS admissions director not start working as December of 2016, the social worker prasked when resider party) are given an stated that resident days before admission conference or upor stated that if the party have them sign the the contract with the #4 stated that if she the resident cannot will send the contract stated that she has mail yet. OSM #4's admissions directors.	oximately 2:30 p.m., Resident preement was requested from		156			

RECEIVED

MAR 0 9 2017

**VDH/QLG** 

On 2/15/17 at 5:15 p.m., an interview was conducted with ASM #1, the administrator and OSM (other staff member) #4, the admissions

staff member) #2, the DON (Director of Nursing) stated, "We cannot locate her old admission agreement. Admissions are trying to get in touch with the RP to come in and sign a new one. If I find the old contract I will show it to you."

On 2/15/17 at 5:00 p.m., ASM #2, the DON stated

that they could not find Resident #18's admission

agreement.

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495045	B. WING	i	C 02/15/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MANORO	CARE HEALTH SERV	CES-RICHMOND		2125 HILLIARD ROAD	
	ANE HEALITI OLIV	OLO-NO/MOND		RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE COMPLETION
	admission contract, several different co that the admission of treatment and billing offender policy, trust and a voluntary arb asked if she would the admissions con RP, OSM #4 stated signature page of the received and under OSM #4 stated that documented acknown and/or RP received OSM #4 stated that placed in the reside resident rights and stated that the hand ook to those the family is not pre On 2/15/17 at 5:00 made aware of the information was pre [1] Wernicke encepheuropsychiatric disincluding changes in ocular abnormalities symptoms can lead mortality. This infor The National Institution of the several distinction of the several difference in the se	ced the purpose of the OSM #4 stated, "It addresses imponents." OSM #4 stated contract had an agreement for g, notification of the sex it fund account information, itration agreement. When document that she went over tract with the resident and/or, "No." OSM #4 stated, "The ne contract is saying that they stand what they are signing." Ithere was no other wledgement that the resident the admissions contract. In a patient handbook is also int's room that addresses the bed hold policy. OSM #4 libook is set up upon arrival. It admissions will read the residents who cannot read if sent.  In m., ASM #2, the DON was above concern. No further sented prior to exit.  In allopathy is an acute lease with symptoms in mental status, ataxia and is; if left untreated, these to morbidity and even to mation was obtained from		RECEIVED MAR 0 9 2017	
				ADH/OFC	

3. Resident #1 was admitted to the facility on

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	D. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495045	B. WING			C 2/15/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	)DE		
MANORO	ADE HEALTH CEON	ICEC DICHMOND		2125 HILLIARD ROAD			
MANUKU	ARE HEALTH SERVI	CES-RICHIMOND		RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE	
F 156	containing consent responsibilities, res responsible party re until 11/18/16.  Resident #1 was at 10/21/16. Resident were not limited to: and diabetes. Resi (minimum data set) an ARD (assessme	ge 23 dent's admission agreement for treatment, facility ident responsibilities and esponsibilities was not signed dmitted to the facility on t #1's diagnoses included but major depressive disorder dent #1's most recent MDS t, a quarterly assessment with ent reference date) of 1/15/17, ts cognition as being severely	F 1	56			
	between Patient an Items" that included responsibilities, res responsible party re	#1's "Admission Agreement d Center" regarding "4 Key d consent for treatment, facility ident responsibilities and esponsibilities was not signed sponsible party until 11/18/16.					
	conducted with OSI (admissions directors since December 20 process for meeting parties and having signed. OSM #4 stresident is being act resident's family and to meet with them a stated she had met before admission by admission agreement admission. OSM #	O a.m., an interview was M (other staff member) #4 or- employed in that position of the control		RECEIVED  MAR 0 9 2017			

unable to sign the agreement then she can send the agreement to the family by certified mail. At

**VDH/CLC** 

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		TE SURVEY MPLETED
495045	B. WING			02	C /15/2017
CES-RICHMOND					
MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOU	D BE	(X5) COMPLETION DATE
ras made aware Resident #1 facility on 10/21/16 and her nt was not signed by her ntil 11/18/16. OSM #4 was by further information as to agreement wasn't signed until a.m., OSM #4 returned to a.m., OSM #4 was no agreement consider a signed and agreement. b.m., OSM #4 was asked the ssion agreement. OSM #4 agreement contained that included an agreement ling, notifications regarding icy and trust fund account, bitration agreement. OSM #4 the information provided in ament, patient handbooks are rooms on admission. OSM ook contains information as, and information specific to was asked if any form was responsible parties to ook was provided upon		156			
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495045  CES-RICHMOND  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)  Ge 24  Vas made aware Resident #1 facility on 10/21/16 and her nt was not signed by her ntil 11/18/16. OSM #4 was y further information as to agreement wasn't signed until a.m., OSM #4 returned to #4 stated there was no lirector at the facility from cember 2016. OSM #4 urther information regarding is ion agreement.  O.m., OSM #4 was asked the ssion agreement. OSM #4 agreement contained that included an agreement ing, notifications regarding icy and trust fund account, bitration agreement. OSM #4 the information provided in ment, patient handbooks are rooms on admission. OSM ook contains information	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495045  B. WING  CES-RICHMOND  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  TAG  TO SUPPLY SU	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495045  B. WING  STEMENT OF DEFICIENCIES IMUST BE PRECEDED BY FULL ISC IDENTIFYING INFORMATION)  Ge 24  Vas made aware Resident #1 facility on 10/21/16 and her nt was not signed by her ntil 11/18/16. OSM #4 was y further information as to agreement wasn't signed until  a.m., OSM #4 returned to #4 stated there was no lirector at the facility from cember 2016. OSM #4 urther information regarding ision agreement.  O.m., OSM #4 was asked the ssion agreement.  O.m., OSM #4 was asked the sion agreement. OSM #4 in agreement contained that included an agreement ling, notifications regarding icy and trust fund account, bitration agreement. OSM #4 the information provided in imment, patient handbooks are rooms on admission. OSM ook contains information es, and information specific to was asked if any form was responsible parties to ook was provided upon	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228  FREMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)  GREAT  GREAT  GROSS-REFERENCED TO THE APPRO DEFICIENCY)  F 156  F	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495045  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLLARD ROAD RICHMOND, VA 23228  FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  GE 24  VAS made aware Resident #1 facility on 10/21/16 and her nt was not signed by her ntil 11/18/16. OSM #4 was yfurther information as to agreement wasn't signed until a.m., OSM #4 returned to #4 stated there was no lirector at the facility from cember 2016. OSM #4 was select the sion agreement. OSM #4 nagreement. OSM #4 nagreement. OSM #4 in agreement. OSM #4 in agreem

RECEIVED

MAR 0 9 2017

**ADH/OFC** 

forms that were signed other than the admission

On 2/15/17 at 2:03 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2

(the director of nursing) were made aware of the

residents/responsible parties was verification that the information was received and understood.

agreement and the signature by the

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	SC EOD MEDICADE	9 MEDICAID SEDVICES			,		APPROVED
		& MEDICAID SERVICES	r			1	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495045	B. WING	i		1	C 15/2017
NAME OF F	PROVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	CES-RICHMOND		2	2125 HILLIARD ROAD		
<i>MATCH</i>	Million III			F	RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLETION DATE
F 156	Continued From pa	ge 25	F 1	156	•		
	above concern.						
	No further informati	on was presented prior to exit.					
	agreement containi facility responsibiliti	the resident's admission ng consent for treatment, es, resident responsibilities ty responsibilities was not after admission.					
	party were not informand responsibilities evidenced by the ac- signed until six days	Resident # 3's responsible med of the rules, their rights, prior to or at admission as Imission contract not being after admission. Resident # 0/1/16 and the Admission d on 9/7/16.					
	9/1/16 and was most 12/7/16 with diagnoral limited to: anemia, proposed by Disease, depression leukemia (cancer of failure to thrive. On (minimum data set), ARD (assessment respectively).	dmitted to the facility on st recently readmitted on sis that included but are not oneumonia, Alzheimer's n, coronary artery disease, the blood cells), and adult the most recent MDS a quarterly assessment with eference date) of 12/13/16, oded as being severely			RECEIVED		
		Resident # 3's admission mented to have been signed after admission.			MAR U 9 2017 VDHOLG		70 T T T T T T T T T T T T T T T T T T T

During an interview on 2/15/17 at 10:50 a.m. with OSM (other staff member) # 4, the admissions director, OSM # 4 was asked what the admission

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			(	OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495045	B. WING			C 02/15/2017
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	
MANOR	CARE HEALTH SERVI	ICES-RICHMOND			25 HILLIARD ROAD CHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
F 156	Continued From pa	age 26	F 1	56	<del></del>	
		nis time OSM # 4 stated that				
	•	this position (Admissions 20/16, and could not speak to				
I		at date. OSM # 4 stated that if	III			
I	a Resident is confu	used then a time is scheduled				
l		Il out the paper work as soon usually occurs a few days				
l.	before admission of	or a few days after admission.			•	
		ompetent then they (the				•
		e admission contract. Many salot going on with the	-		•	
	admission she reac	ches out to the family first. If				
		e Resident is not competent ach the family then the				
		ich the family then the :: is sent by certified mail. At				
	this time OSM was	given the name of Resident#	6 8			
		e was any documentation as to elay in the signing of the	i			
	Resident's admission					!
		on 2/15/17 at 11:37 a.m. with stated that the person that did				
		ission contract was no longer	***************************************			
	at the facility. OSM	# 4 stated that she could find				
	no notes concerning contract.	g the delay in signing of the			•	
		on 2/15/17 at 2:00 p.m. with e Staff Member) # 1, the				
		# 2, the director of nurses,				1
	and ASM # 4, the co	orporate quality assurance				İ
	staff, the lateness o	of the signing of Resident # 3's				

Admission Contract was. OSM # 4 stated it had

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

ASM # 1 and OSM # 4, the lateness of the Admission Contract signatures was discussed.

During an interview on 2/15/17 at 5:10 p.m. with

OSM # 4 was also asked what the purpose of the

Admission Contract was reviewed.

Event ID: ODYV11

Facility ID: VA0241

RECEIVED

MAR 09 2017

VDH/OLG

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u> DMR NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495045	B. WING	i		1	C /1 <b>5/2017</b>
NAME OF F	PROVIDER OR SUPPLIER	A		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	2125 HILLIARD ROAD		•
MANOR	CARE HEALTH SERV	ICES-RICHMOND		F	RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 156	several component information: Treatr Fund, and Voluntar	nge 27 s which included the following ment, Billing, Resident Trust y Arbitrator Agreement to # 4 stated at the time the	<b>F</b> '	156			
	contract is signed to Package. This pack room and includes Resident's Rights, of the rules of the fishe follows up with has it signed. The they have received OSM # 4 stated that	he Resident gets a Welcome kage is put into the Resident's the Patient Handbook, Bed Hold Policy, and advises acility. OSM # 4 stated that the admission contract and Signature is verification that and understand the contract at if a Resident cannot read the rature is read to the Resident.	A STATE OF THE STA				
	•	s presented prior to exit.  I, facility staff failed to inform					
	rights, rules, and re	P (responsible party) of her sponsibilities of her stay at the he was admitted on 1/24/17.	:				
	1/24/17 with the dia colon cancer, press and was on Hospic MDS (Minimum Da assessment with al Reference Date) of coded as being cog daily life decisions. extensive assistance with transupervision for eati	admitted to the facility on agnoses of but not limited to sure sore, prostate hyperplasia e services. The most recent ta Set) was the admission ARD (Assessment 1/31/17. The resident was unitively intact in ability to make the resident required the with bathing; limited asfers and dressing; and hygiene; and had an and catheter for bladder.	=		RECEIVED		
	A review of the nurs	se's notes revealed an			MAR 0 9 2017		

admission note dated 1/24/17 at 2:30 p.m., which documented, "Patient admitted to unit from

VDH/OLG

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB I	VO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO		E CONSTRUCTION		DATE SURVEY COMPLETED
		495045	B. WING	i			C <b>02/15/2017</b>
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-RICHMOND		21	REET ADDRESS, CITY, STATE, ZIP CODE 125 HILLIARD ROAD ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 156	A review of the admadmission paperwo (POA - power of attrapproximately 8 days On 2/15/17 at 4:00 conducted with OSI the admissions dire was a previous admand the department completing the admisspeak to or specific incident.  As the administrator Member #1) was previous admandation.	ner accompanied by sister"  dission contract revealed the rk was signed by the sister orney) on 2/1/17;	F	156			
	conducted with ASN asked the purpose of OSM #4 stated, "It a components." OSM contract had an agrebilling, notification of fund account inform arbitration agreemed document that she was contract with the resistated, "No." OSM # of the contract is say understand what the stated that there was acknowledgement the output of the contract is say understand what the stated that there was acknowledgement the output of the contract is say understand what the stated that there was acknowledgement the output of the contract is say understand what the stated that there was acknowledgement the output of the contract is say understand what the stated that there was acknowledgement the output of the contract with the output of the contract is say understand what the stated that there was acknowledgement the output of the contract in the contract is say understand the co	o.m., an interview was I #1 and OSM #4. When of the admission contract, addresses several different I #4 stated that the admission eement for treatment and If the sex offender policy, trust ation, and a voluntary int. When asked if she would event over the admissions ident and/or RP, OSM #4 If stated, "The signature page ying that they received and ey are signing." OSM #4 Is no other documented that the resident and/or RP			RECEIVED  MAR 0 9 2017  VDH/OLG		

received the admissions contract. OSM #4 stated that a patient handbook is also placed in the resident's room that addresses resident rights

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	49 FOR MEDICARE	& MEDICAID SERVICES				14D 14C. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495045	B. WING			C
	· · · · · · · · · · · · · · · · · · ·	493043	L. Wild			02/15/2017
	PROVIDER OR SUPPLIER			ĺ	EET ADDRESS, CITY, STATE, ZIP CODE 5 HILLIARD ROAD	
MANORO	CARE HEALTH SERVI	CES-RICHMOND		RIC	HMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	BE COMPLETION
F 156	handbook is set up that admissions will residents who cann present.	ge 29 blicy. OSM #4 stated that the upon arrival. ASM #1 stated read the handbook to those ot read if the family is not on was provided by the end of	<b>F</b> ·	156		
F 176 SS=D	the survey. 483.10(c)(7) RESID	ENT SELF-ADMINISTER	F	176	F-176	3/31/17
	the interdisciplinary §483.21(b)(2)(ii), ha practice is clinically This REQUIREMENT by: Based on observation interview, facility do record review, it was staff failed to assess medication self-admiresidents in the sure the resident self-administering in The findings include Resident #14 was a 4/27/12. Resident were not limited to:	ion, resident interview, staff cument review and clinical s determined that the facility s a resident prior to ninistration for one of 29 vey sample, Resident #14.  ed to assess Resident #14 to was capable of nedicated topical creams.			It is the intended practice of the facility to honor a resident's rig to self-administer drugs if the interdisciplinary team, as define by 483.20(d)(2)(ii), has determined that this practice is safe.  Criteria 1  Upon notification from surveyor all medications were removed from the resident #14 possession MD notified, orders clarified resident #14 assessed and found be able to administer medication as ordered self-administration form completed and plan of care revised.	cht ed s r, n. I to
	pressure. Resident (minimum data set) an ARD (assessme	in syndrome and high blood #14's most recent MDS , a quarterly assessment with nt reference date) of 1/27/17, as being cognitively intact.		ĺ	RECEIVED MAR 0 9 2017	

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTELLO	I OIT MEDIONITE	- OF INCOMPANIES AFILIATORS				V1712 11	<u> </u>
STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED	
		495045	B. WING			0	C <b>2/15/2017</b>
NAME OF PRO	VIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP COD	E	
MANORCARE HEALTH SERVICES-RICHMOND				2125 HILLIARD ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIEN		ION SHOULD BE COMPLETIC HE APPROPRIATE DATE	
			; ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	•			3/31/17

#### F 176 Continued From page 30

Section G coded Resident #14 as requiring supervision with one person physical assist with bed mobility, transfers, eating and toilet use. The resident was coded as requiring limited one person physical assist with dressing and supervision with setup help only with personal hygiene.

Resident #14's current physician order summary documented orders including but not limited to: benzoyl peroxide (1) 5% gel to be topically applied to the resident's scalp lesions every day, Nystop powder (2) 100,000 unit/one gram to be applied to the resident's groin twice daily as needed and Proctozone (3) 2.5% cream to be applied four times daily as needed for hemorrhoids. There was no current physician's order for nystatin cream (4) or triamcinolone cream (5).

Resident #14's February 2017 TAR (treatment administration record) documented physician's orders including but not limited to: benzoyl peroxide 5% gel to be topically applied to the resident's scalp lesions every day, Nystop powder 100,000 unit/one gram to be applied to the resident's groin twice daily as needed and Proctozone 2.5% cream to be applied four times daily as needed for hemorrhoids. There was no documented order for nystatin cream or triamcinolone cream.

Resident #14's comprehensive care plan revised on 2/8/17 documented, "Focus: Recurrent Yeast Rash at groin area...Interventions: Administer treatment per physician orders...Focus: At risk for alteration in skin integrity related to: incontinence, impaired mobility. Resident has reoccurring lesions to scalp...Interventions: Apply

F 176

#### Criteria 2

Any and all residents who are alert and oriented x4 have the potential to be affected.

#### Criteria 3

All licensed nurses will be reeducated on the nursing procedures for medication self-administration and clarification of MD orders.

#### Criteria 4

DON or designee will randomly audit 5 residents rooms daily x5 days, 3 times weekly x3 weeks, monthly x2 months to ensure that resident who have medications in the rooms have the orders, assessments completed and meets self-administration requirements.

#### Criteria 5

The facility's alleged date of compliance is 3/31/2017.

RECEIVED

MAR 0 9 2017

VDH/QLC

PRINTED: 02/28/2017

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			0	MB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495045	B. WING	· · · · · · · · · · · · · · · · · · ·		C 02/15/2017
NAME OF P	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZII	CODE	
14411000	MANOPOADE HEALTH CERUICES DICHMOND			2125 HILLIARD ROAD		
MANORCARE HEALTH SERVICES-RICHMOND			1	RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD HE APPROPI	BE COMPLETION
	doctor) orders" Todocument informatic self-administration of Further review of Refailed to reveal evide been assessed for the facility, multiple were observed on Four tubes of medic on Resident #14's son 2/15/17 at 11:05 sitting in a wheelchar resident's permission four tubes of medic the resident's sink.  One 3/4 full tube or and one 1/2 full tube gram cream. Residents	resident scalp per md (medical he care plan failed to on regarding of medicated creams.  esident #14's clinical record ence that Resident #14 had medication self-administration.  I a.m. during the initial tour of tubes of medicated cream Resident #14's sink.  p.m., Resident #14 was sitting is room watching television. cated cream were observed				

RECEIVED

MAR 0 9 2017

VDH/OLG

During the above observation, Resident #14 confirmed he applies the medicated creams himself. When asked if nurses had ever watched him apply the creams or had educated him about

-Also noted were two plastic spoons with dried

-One 1/3 full tube of benzovi peroxide 5% gel and one 3/4 full tube of Proctozone 2.5% cream. Resident #14 stated he used those creams for

creams up and put them on himself.

cream residue.

lesions on his head.

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED		
		495045	B. WING			1	C 15/2017		
NAME OF F	PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE				
MANORO	CARE HEALTH SERVI	CES-RICHMOND			S HILLIARD ROAD HMOND, VA 23228				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 176	nurses used to com that he knew how to creams on himself.  On 2/15/17 at 11:20 conducted with LPN (Resident #14's nur facility process regard creams and resident medicated creams. Creams are kept stonurses can obtain a medication at the bresidents were allowereams if there was at the bedside. LPI they are cognitive enurses conduct an resident self-administated there was no residents, explain that the explain that the the residents and the applying the creams Resident #14's medication and the applying the creams Resident #14's medication the resident was not resident to the resident that the creams and the applying the creams at asked if the nurses	reams, the resident stated he into the room but they knew or mix the creams and put the distribution and interview was all (licensed practical nurse) #1 reset. LPN #1 was asked the arding storage of medicated has self-administration of LPN #1 stated medicated ored in the treatment cart but a physician's order to keep the redside. LPN #1 was asked if reasessment prior to allowing a respective to them and then resplain the process back to LPN #1 was made aware this medicated creams in Resident resident stated he had been as himself. LPN #1 stated dicated creams should have atment cart and should not sident's room because she tidd not have an order to the bedside. LPN #1 was ever administered the creams PN #1 stated sometimes	: -		RECEIVED  MAR 0 9 2017				
	nurses did and the	creams may have accidentally n. LPN #1 was asked if			VDH/OLG				

Resident #14 had ever been assessed to see if he was capable of self-administration of medicated creams. LPN #1 stated, "As far as

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495045	B. WING	<del></del>	-	C <b>02/15/2017</b>		
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
MANORCARE HEALTH SERVICES-RICHMOND					5 HILLIARD ROAD SHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE COMPLÉTION		
F 176	and clean himself up the resident was cat LPN #1 stated, "I'm because we have begoing to say it's door based on what I've was going to call the the medicated creat #14's bedside.  On 2/15/17 at 2:03 staff member) #1 (the director of nurse above concern.  The facility docume self-administration of advised of my rights medication, when the determined that this cautioned on the ris self-administration approcedures are estamy drug regimen. The regulation, please in administration. (Pleated William): (Two option medication(s) administer my redetermined, by the laste." A signature as and "Facility Representation of the form ASSESSMENT OF SELF-MEDICATE."	seen him go to the bathroom p." When asked if that meant pable of self-administration, still going to say he is capable een in the room. I'm not sumented but say he can say seen." LPN #1 stated she enurse practitioner to see if ms could be left at Resident p.m., ASM (administrative he administrator) and ASM #2 ing) were made aware of the nt regarding medication documented, "I have been to self-administer ne Interdisciplinary Team has a practice is safe. I have been			ECEIVED MAR U 9 2017 DH/OLG			

practice, a nurse will conduct the following test. If the patient is unable to demonstrate knowledge to assure safe self-administration of medications,

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u>OMB NO. 0938-0391</u>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495045	B. WING		C <b>02/15/2017</b>		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
			1	2125 HILLIARD ROAD			
MANORO	CARE HEALTH SERVI	CES-RICHMOND		RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT: ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION		
F 176	allowed. DIRECTIC currently prescribed questions for each patient's response: OF THIS DRUG? ITHIS DRUG? WHATAKE THIS DRUG? WHATAKE THIS DRUG'DRUG?STEP III SOF PATIENT SELF MEDICATION- To econsistently take the appropriate time, a taking their medication was tak back if the patient in not manage opening. Note- the above for present in the clinic facility staff.  No further information obtained from the whitps://www.ncbi.nlir.T0009244/?report= (2) Nystop powder infections. This infetthe website:	of medication will not be DNS: Hand the patient each a medication, ask the following medication, and record the WHAT IS THE STRENGTH HOW OFTEN DO YOU TAKE AT TIME OF DAY DO YOU? WHY DO YOU TAKE THIS SEVEN DAY EVALUATION ADMINISTERING evaluate the patient's ability to eir medication at the nurse will observe the patient tion for a seven day period. If the MAR to indicate that the en and will write a note on the lad to be reminded or could go or pouring the medication"  In for Resident #14 was not all record or presented by the information was website:  In his information was website:  In his used to treat fungal ormation was obtained from	F 1	RECEIVED MAR 0 9 2017			
	•	.gov/druginfo/meds/a682758.h		VDH/OLG			

(3) Proctozone is used to treat itching and swelling caused by hemorrhoids. This

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O!	MB NO.	0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495045	B. WING			C 02/15/2017		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MANOR	CARE HEALTH SERV	CES PICHMOND		2	125 HILLIARD ROAD			
IN/G4OIC	OAKE HEALIH OLKVI			F	RICHMOND, VA 23228			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT AG CROSS-REFERENCED TO THE APPRINT DEFICIENCY)		JLD BE COMPLETION		
F 176	Continued From page 35		· F1	176	76			
	information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDru gXsl.cfm?setid=fb5746ff-3ff1-4874-a827-469413 3641b9  (4) Nystatin cream is used to treat fungal infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682758.h tml			170				
			<u>:</u>					
	and inflammation of was obtained from t	used to treat itching, redness the skin. This information he website: gov/druginfo/meds/a601124.ht					Account to the second s	
		TO NOTICE BEFORE	F 2	247		9	121/10	
SS=D	ROOM/ROOMMAT	E CHANGE			F-247	ے	/31/17	
	(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by:  Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to orient one of 29 sampled residents, (Resident #1) to a new room prior to moving the resident.				It is the intent of this facility to honor a resident's right to receive notice before the resident's room is changed or roommate in the facility is changed.  Criteria 1	ve n		
	The facility staff faile	ed to orient Resident #1 to a duce the new roommate prior			Staff has followed up with reside #1, her responsible party and roommates to ensure that this change did not affect them	nt (		
	The findings include				mentally or socially. And all involved are fine and prefer to			
	Resident #1 was add	mitted to the facility on			continue to room together.			

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

10/21/16. Resident #1's diagnoses included but

Event ID: ODYV11

RECEIVED

If continuation sheet Page 36 of 134

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED C 02/15/2017	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-RICHMOND				STREET ADDRESS, CITY, STATE, ZIP COD 2125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRE  X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
· · · · · · · · · · · · · · · · · · ·			<del>- i</del>	3		3/31/17

#### F 247 Continued From page 36

were not limited to: pressure ulcer (1), major depressive disorder and diabetes. Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/15/17, coded the resident's cognition as being severely impaired. Section G documented, Resident #1 required extensive assistance of two or more staff with transfers and was totally dependent of one staff with locomotion on the unit.

Resident #1's January 2017 ADL (activity of daily living) records documented the resident required extensive assistance of one staff with transfers during some days in January 2017; was totally dependent of one staff with transfers during some days in January 2017 and was totally dependent of two or more staff with transfers during some days in January 2017.

Review of Resident #1's clinical record revealed a nurse's note dated 1/6/17 that documented, "Resident transferred from the Parc unit to room (room number) the third bed today." Further review of nurse's notes and social services notes failed to reveal Resident #1 was afforded the opportunity to see the new room or meet the new roommate prior to the move. The notes also failed to document the resident's responsible party was notified of the room change.

Review of Resident #1's comprehensive care plan initiated on 10/21/16 and revised on 2/15/17 failed to document information regarding a room change.

On 2/15/17 at 9:37 a.m., an interview was conducted with OSM (other staff member) #10 (the social services director- employed at the

#### F 247

Criteria 2

Any and all residents have the potential to be affected.

#### Criteria 3

The interdisciplinary team will be re-educated on the residents' rights to notice before room/roommate change. To include but not limited to introduction, orientation to room/roommate.

#### Criteria 4

DON or designee will audit notification assessments for new admissions and all room/roommate changes via Eagle room dailyx5days, 3times weeklyx3weeks, monthlyx2months.

#### Criteria 5

The facility's alleged date of compliance is 3/31/2017.

RECEIVED

MAR 0 9 2017

ADH/OFC

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					O	MB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
•				-		c	
		495045	B. WING			02/15/2017	
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
BARNODO	NADE REALTH CEDA	ICEC DICUMOND		212	5 HILLIARD ROAD		
MANORU	CARE HEALTH SERVI	CES-RICHMOND		RIC	HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X .	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 247	facility for one mont services coordinated facility process regation and stated the social resident, the resident responsible party at responsible party at responsible party when asked if Resident resi	th) and OSM #8 (the social or). OSM #10 was asked the arding room changes. OSM all services staff notifies the ent's responsible party and the the room the other resident is #10 stated the social services a resident the new room dent to the new roommate and from the residents. At this asked if this process was esident #1 moved on 1/6/17. In notified Resident #1 and the ble party of the room change. In had to call the resident's at the time because the ras out of town. OSM #8 of the document notification. In the new room and meet the first of the room change, OSM #8 was bed bound so she own the new room or allowed ommate. When asked how ent was bed bound, OSM #8 said the resident had wounds at of bed. When asked who #8 stated she couldn't a.m., an interview was (registered nurse) #2 (Parc #2 was asked if Resident #1	F 2		RECEIVED		
	was bed bound dur	ing the time period of 1/6/17 moved to a new room. RN #2			MAR 0 9 2017		
	stated the resident	had a sacral wound (wound			rimin V J ZUII	ļ	

on the resident's bottom) and would get up in a

chair an hour at a time but was in bed a lot. When asked if it would have been possible for the

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0391				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495045	B. WING	i	<u> </u>	C 02/15/2017	
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-RICHMOND			25 HILLIARD ROAD CHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETION	
F 247	resident to be whee	eled to her new room and meet		247			
	On 2/15/17 at 9:50 conducted with RN care nurse). RN #7 was bed bound duri when the resident n stated although the bed at times, the re getting up into a "Gochair) for one to two	·					
	conducted with OSI to her knowledge, F see her new room of prior to the 1/6/17 of thought the resident stated the reason for because the resident care bed because the exhausted. At this to aware this surveyor stated Resident #1 time period of 1/6/1 comments.	a.m., another interview was M #8. OSM #8 confirmed that Resident #1 was not taken to or meet her new roommate come change because she twas bed bound. OSM #8 or the room change was not had to move to a long term had to move to a long term had spoken to other staff who was not bed bound during the 7. OSM #8 had no further					
	staff member) #1 (ti	p.m., ASM (administrative ne administrator) and ASM #2 ing) were made aware of the			RECEIVED		
	The facility social separt, "Social Service	ervice manual documented in e Role: Reasonably			MAR 0 9 2017	-	

accommodate patient preferences when considering a change in room or roommate. Assist with notification to the patient or

responsible party of the change, the reason for

PRINTED: 02/28/2017 FORM AP:PROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		495045	B. WING			2/15/2017
	PROVIDER OR SUPPLIEF  CARE HEALTH SER			STREET ADDRESS, CITY, STATE, ZIP CO 2125 HILLIARD ROAD RICHMOND, VA 23228	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 247	the patient with the Introduce the patient	espond to questions. Introduce e room before the move. ent to the new roommate"		247		
F 250 SS=D	(1) "A pressure inj damage to the ski usually over a born medical or other das intact skin or an painful. The injury and/or prolonged combination with stissue for pressure affected by microco-morbidities and This information whitp://www.npuap.clinical-resources/483.40(d) PROVIS RELATED SOCIA			250 F-250		3/31/17
	social services to practicable physic well-being of each This REQUIREME by: Based on staff intreview, clinical recomplaint investig the facility staff fair social services for	st provide medically-related attain or maintain the highest al, mental and psychosocial resident.  ENT is not met as evidenced erview, facility document cord review and in the course of ation, it was determined that led to provide medically related two of 29 residents in the esident # 23 and Resident #1.		It is the intended practice facility to provide medical related social services to an maintain the highest practice physical, mental, and psychwell-being of each resident process of the	ally- ttain or ticable tosocial	-
		ne facility staff was aware that unable to read or write and		MAR 0 9 2017		

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS	EOR MEDICARE	& MEDICAID SERVICES			O		0938-0391
STATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		E SURVEY
AND PLAN OF CO		IDENTIFICATION NUMBER:	A. BUILD				PLETED
	1					1	С
		495045	B. WING			02/	15/2017
NAME OF PROV	VIDER OR SUPPLIER			l	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORCAR	E HEALTH SERVI	CES-RICHMOND			125 HILLIARD ROAD RICHMOND, VA 23228		
	CUI BAADV CTA	TO IT OF DETICIENCIES			<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
		i	<u>int</u>	5	Critoria 1	***************************************	3/31/17
F 250 Co	ontinued From pag	ge 40	F 2	250	<u>Criteria 1</u> Upon notification from surveyors,		-
		nce in the clinical record that			resident #23 has been discharged		
		staff assisted Resident #23			from facility, social workers and		
		the admissions contract or ne Medicaid application			admission director have been re-		
	sisteu niin with th OCESS.	e Medicaid application			educated to help residents		
•					understand admission contracts		
		ces staff failed to introduce			and social workers to help with		
		ew room and new roommate			Medicaid application process as		
þne	or to a room char	1ge on 1/6/17.			needed. Social services staff has		
					followed up and assessed resident	t	
The	e findings include	e:			#1's physical, mental and		
					psychosocial well-being as it		
		e facility staff was aware that in the land	i		relates to her new room and		
		nce in the clinical record that			roommates. Resident#1 and		
		staff assisted Resident #23	٠		grammatical and the second		
witl	h understanding	the admissions contract or			roommates are transitioning well	i	
		ne Medicaid application			together.		
þro	ocess.						
Re	sident #23 was a	admitted to the facility on			Criteria 2		
8/3	3/16 with diagnose	es that included, but were not	<u> </u>		Any and all residents have a		·
		ttack, back pain, peripheral	:		potential to be affected.		
vas	scular disease, di	iabetes and difficulty walking.					
Re	sident #23's mos	st recent MDS (minimum data					
set	t) was a quarterly	assessment with an ARD					
1		nce date) of 11/9/16.					
		coded on the MDS as having a	1				
		w for mental status) score of RAI (resident assessment	-	ļ	RECEIVED		
		documents that a score of 13					
		sident's cognition is intact.			MAR 0 9 2017		

A review of Resident #23's clinical record revealed a hospital discharge summary that contained, in part, the following documentation; "8/3/26 VSS (vital signs stable), found sitting in

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FU	JK MEDICAKE	& MEDICAID SERVICES			או מואוט	O. 0330-033	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLE CONSTRUCTION HNG		(X3) DATE SURVEY COMPLETED	
		495045	B. WING			C ) <b>2/15/2017</b>	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-RICHMOND				STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228		Value and descriptions	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE	
			:	,		3/31/17	

#### F 250 Continued From page 41

chair (referring to Resident #23) in no acute distress. Pt (patient) cannot read / write, has never been to school. Pt will need continuous teaching while at (name of facility) and close follow up with PCP (primary care physician)."

Further review of Resident #23's clinical record revealed, in part, a facility form "Social Service Assessment & (and) History" that was completed on 8/9/2016 following admission of Resident #23 on 8/3/16. Under the area named "Dignity Factors" Resident #23 was checked as having "Chronic disabling medical / psychological condition." There were no areas checked under "Social Factors" and there were no other areas related to Resident #23's inability to read or write.

Further review of Resident #23's clinical record revealed that the social services director documented two meetings with Resident #23 that occurred on 10/20/16 and 11/8/16. Both meetings discussed Resident #23's discharge plan.

A review of Resident #23's comprehensive care plan dated 8/3/16 did not reveal any information regarding Resident #23's inability to read or write and / or the need for staff to read documents to Resident #23 and ensure comprehension.

There was no documentation in the clinical record that evidenced the social services staff provided ongoing support to ensure that Resident #23 was aware of the admission contract requirements and the billing changes. There was no documentation in the clinical record that evidenced the social services department provided assistance to Resident #23with the Medicaid application process.

#### F 250

#### Criteria 3

Social workers have been reeducated on providing residents with social services need that meet physical, mental and psychosocial wellbeing not limited to room changes and ensuring that resident /RP understand information provided and will continue monitoring of these services to ensure prevision for all potential residents.

#### Criteria 4

Administrator or designee will interview new admissions for understanding of the information provided in the admission contracts, oriented to rooms/roommates daily x5 days, three days weekly x3 weeks, and monthly x2 months.

#### Criteria 5

The facility's alleged date of compliance is 3/31/2017.

RECEIVED

MAR 0 9 2017

PRINTED: 02/28/2017

		& MEDICAID SERVICES			C		. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1''		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495045	B. WING			i	C <u>/15/2017</u>
	PROVIDER OR SUPPLIER  CARE HEALTH SERV	ICES-RICHMOND		21	TREET ADDRESS, CITY, STATE, ZIP CODE 125 HILLIARD ROAD IICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 250	Continued From pa	ge 42	F2	250			
	conducted with OS director. OSM #10 process of the socinew admission from stated, "We start w If the resident is go anticipate the need	a.m. an interview was M #10, the social services was asked to describe the al services department for a n the hospital. OSM #10 ith an admission assessment. ing to a skilled unit we s of the resident, d/c g, and family support, medical					

On 2/15/16 at 9:09 a.m. an interview was conducted with OSM #4, the admissions director (formerly the social services director). OSM #4 was asked if she remembered Resident #23. OSM #4 stated that she did, but not remember the details. OSM #4 asked to review Resident #23's case and then get back to this surveyor. OSM #4 did not return to this surveyor with any specific information regarding Resident #23's situation.

and physical needs once they return to their home. We get a general sense of the length of time they (the resident) will be here." OSM #10 was asked the role of the social services

department if the resident is a candidate for long term care placement. OSM #10 stated, "We focus on the financial aspect, we will start the Medicaid process, we guide the resident and explain where to apply. The business office takes the lead." OSM #10 was unable to discuss anything about Resident #23 as she was not employed at the facility during Resident #23's

On 2/15/17 at 9:45 a.m. an interview was conducted with OSM #8, the social services coordinator. OSM #8 was asked if she remembered working with Resident #23 during RECEIVED

MAR 0 9 2017

VDH/OLC

stay.

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495045	B. WING			l	C <b>15/2017</b>
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				21:	25 HILLIARD ROAD		
MANOR	CARE HEALTH SERVI	CES-RICHMOND	1	RI	CHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	Continued From pa	ge 43	F 2	250			
	•	y. OSM #8 stated that she		.00			
		n the resident on discharge					
		was asked when she started					
		ent #23. OSM #8 stated,					
		"." OSM #8 was asked					
		dent #23 was able to read or					
	write. OSM #8 state	ed, "I am not sure, he did					
		ding when I spoke with him."					
		if she helped Resident #23					
		contract or with initiating a					
		n. OSM #8 stated, "I think that					
		started something, but I don't #8 stated that she had talked					
		ot" and when asked whether					
		ated the conversations, OSM					
		ocumented in the computer					
		notes would be found in the					
		SM #8 was shown the two					
	handwritten docume	ents that were provided to this					
		ed to review the computer					
		M #8 stated, "If the notes are					
	not in PCC then it w	asn't documented."					
		a.m. an interview was					
		1 (administrative staff					
		ministrator. ASM #1 was					1
		above findings. ASM #1					
		ware that Resident #23 could of that was the case then					
		nave been provided orally and #1 was asked what should			RECEIVED		-
		dent is admitted to the facility			- Tenner or to 4000000 Except		
	• •	are is provided to meet the			MAR <b>0</b> 9 2017		
		racticable level of function.			· · · · · · · · · · · · · · · · · · ·		7
		the staff would go over their			VDH/OLG		
		of care, financial information,					1
		meeting and provide the					
		e. ASM #1 was made aware					

at this time that although a care plan was

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

							MERKOVED
CENTERS FOR MEDICARE & MEDICAID SERVICES						<u>OMB NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION		E SURVEY IPLETED
		495045	B. WING	i		l l	C / <b>15/2017</b>
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-RICHMOND			5 HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 250		ge 44 as no evidence that Resident nation about the financial	F:	250			,
	aspect of his stay or regarding his care a policy regarding the	r any other information at the facility. At this time a admissions process was th a job description for the					
	Worker" revealed, i documentation; "So Provides assistance admission to assure Contacts the new reas needed to ensur and that difficulties resident / patient fa Medicare / Medicaie	lity job description titled "Social n part, the following ocial Worker Responsibilities. It with the resident's / patient's e a smooth transition; esident / patient and / or family the that needs are being met are being resolved. Informs mily or legal representative of d program benefits and assists these alternative funding ag home care."					
	by the facility, reveal documentation; "So Regulations: The services are used to psychosocial needs coordinate the deliv services. This coul but are not limited to the rights of each p discharge. New Ad	cial Service Manual" provided aled, in part, the following social Service Role and kills of those providing social of evaluate and clarify patients and to obtain, provide or very of medically related social dinvolve actions that include, to the following: advocating for attent from admission through mission: The social service ant role in a newly admitted to the center."			RECEIVED  MAR 0 9 2017  VDH/OLG		

end of the survey process.

No further information was provided prior to the

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495045	B. WING		C 02/15/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORCARE HEALTH SERVICES-RICHMOND				2125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 250 Continued From page 45		, F 2	50			
	Resident #1 to a ne	es staff failed to orient w room and introduce the new a room change on 1/6/17.	÷			
Resident #1 was admitted to the facility on 10/21/16. Resident #1's diagnoses included be were not limited to: pressure ulcer (1), major depressive disorder and diabetes. Resident # most recent MDS (minimum data set), a quart assessment with an ARD (assessment referer date) of 1/15/17, coded the resident's cognition as being severely impaired. Section G documented, Resident #1 required extensive assistance of two or more staff with transfers a was totally dependent of one staff with locomo on the unit.		t #1's diagnoses included but pressure ulcer (1), major r and diabetes. Resident #1's minimum data set), a quarterly n ARD (assessment reference ded the resident's cognition mpaired. Section G lent #1 required extensive r more staff with transfers and	The state of the s			
	living) records docu extensive assistance	ary 2017 ADL (activity of daily mented the resident required to one staff with transfers an January 2017; was totally				

RECEIVED

MAR 09 2017

VDH/OLG

Review of Resident #1's comprehensive care plan initiated on 10/21/16 and revised on 2/15/17

opportunity to see the new room or meet the new roommate prior to the move. The notes also

failed to document the resident's responsible party was notified of the room change.

dependent of one staff with transfers during some days in January 2017 and was totally dependent of two or more staff with transfers during some

Review of Resident #1's clinical record revealed a nurse's note dated 1/6/17 that documented, "Resident transferred from the Parc unit to room (room number) the third bed today." Further review of nurse's notes and social services notes failed to reveal Resident #1 was afforded the

days in January 2017.

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICAR	E & MEDICAID SERVICES				0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	495045	B. WING		ŀ	C 15/2017
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 125 HILLIARD ROAD ICHMOND, VA 23228		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
change.  On 2/15/17 at 9:3' conducted with Ost (the social services facility for one mo services coordinated facility process registry process registry process registry for a stated the social resident responsible party responsible party responsible party responsible party confirmed she did When asked if Reopportunity to see new roommate pristated the resident probably wasn't she to meet the new reshe knew the resident res	t information regarding a room  7 a.m., an interview was SM (other staff member) #10 s director- employed at the inth) and OSM #8 (the social for). OSM #10 was asked the garding room changes. OSM sial services staff notifies the ent's responsible party and the in the room the other resident is I #10 stated the social services he resident the new room ident to the new roommate and from the residents. At this is asked if this process was Resident #1 moved on 1/6/17. It notified Resident #1 and the sible party of the room change. It had to call the resident's at the time because the was out of town. OSM #8 in't document notification. Sident #1 was afforded the the new room and meet the or to the room change, OSM #8 t was bed bound so she frown the new room or allowed bommate. When asked how dent was bed bound, OSM #8 said the resident had wounds ut of bed. When asked who #8 stated she couldn't	F 250	RECEIVED		
remember. On 2/15/17 at 9:45	5 a.m., an interview was		MAR 0 9 2017 VDH/OLG		
	I (registered purse) #2 (Pers		VWMV		

conducted with RN (registered nurse) #2 (Parc unit manager). RN #2 was asked if Resident #1

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495045	B. WING_		02/15/2017
	NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERV	ICES-RICHMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228	
-	PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE COMPLETION
1		····			<del></del>

#### F 250 Continued From page 47

was bed bound during the time period of 1/6/17 when the resident moved to a new room. RN #2 stated the resident had a sacral wound (wound on the resident's bottom) and would get up in a chair an hour at a time but was in bed a lot. When asked if it would have been possible for the resident to be wheeled to her new room and meet her new roommate, RN #2 stated, "Possibly."

On 2/15/17 at 9:50 a.m., an interview was conducted with RN (registered nurse) #7 (wound care nurse). RN #7 was asked if Resident #1 was bed bound during the time period of 1/6/17 when the resident moved to a new room. RN #7 stated although the resident refused to get out of bed at times, the resident was occasionally getting up into a "Geri chair" (a special reclining chair) for one to two hours a day.

On 2/15/17 at 9:55 a.m., another interview was conducted with OSM #8. OSM #8 confirmed that to her knowledge, Resident #1 was not taken to see her new room or meet her new roommate prior to the 1/6/17 room change because she thought the resident was bed bound. OSM #8 stated the reason for the room change was because the resident had to move to a long term care bed because her Medicare benefits had exhausted. At this time, OSM #8 was made aware this surveyor had spoken to other staff who stated Resident #1 was not bed bound during the time period of 1/6/17. OSM #8 had no further comments.

On 2/15/17 at 2:03 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

F 250

RECEIVED

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION		TE SURVEY MPLETED
		495045	B. WING			02	C / <b>15/2017</b>
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-RICHMOND		212	EET ADDRESS, CITY, STATE, ZIP CODE 5 HILLIARD ROAD :HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 278 SS=D	The facility social separt, "Social Service accommodate patie considering a change Assist with notification responsible party of the change and rest the patient with the Introduce the patient with the Introduce the patient (1) "A pressure injurdamage to the skin usually over a bony medical or other deas intact skin or an painful. The injury of and/or prolonged prombination with ships tissue for pressure affected by microcli co-morbidities and of This information was http://www.npuap.or.clinical-resources/ng483.20(g)-(j) ASSES ACCURACY/COOF	ervice manual documented in a Role: Reasonably and preferences when ge in room or roommate. So to to the patient or a fine change, the reason for pond to questions. Introduce room before the move. In the to the new roommate"  In on was presented prior to exit. In the injury can present open ulcer and may be ressure or related to a vice. The injury can present open ulcer and may be ressure or pressure in rear. The tolerance of soft and shear may also be mate, nutrition, perfusion, condition of the soft tissue." In sobtained from the website: reg/resources/educational-and-puap-pressure-injury-stages/SSMENT RDINATION/CERTIFIED  ressments. The assessment fect the resident's status.		250	F-278  It is the intended practice of facility to have an assessment accurately reflects the reside status.	that	3/31/17

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

(i) Certification

Event ID: ODYV11

FRECEIVED

If continuation sheet Page 49 of 134

MAR 0 9 2017



PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS	FOR MEDICARE	& MEDICAID SERVICES			0		0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495045	B. WING	·		1	C 15/2017
	OVIDER OR SUPPLIER RE HEALTH SERVI	CES-RICHMOND		21	REET ADDRESS, CITY, STATE, ZIP CODE 25 HILLIARD ROAD ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
(1 th (2 a)	e assessment is o	se must sign and certify that completed.  who completes a portion of the ign and certify the accuracy of		278	Criteria 1 Upon notification from surveyor residents #9's height has been modified and resubmitted. Resident#11's weight has been modified and resubmitted	MAAAA	3/31/17
(1 w (i) re pi	ho willfully and kn ) Certifies a mater esident assessme	and Medicaid, an individual			Resident #11 sections O has been modified and resubmitted Resident #12 section H has be modified and resubmitted	n	
aı sı \$8	nd false statement ubject to a civil mo 5,000 for each ass	ement does not constitute a			Criteria 2  All residents have the potential to be affected.  Criteria 3	œ	
Ti by E re st (n re	his REQUIREMEN	ion, staff interview and clinical s determined that the facility ain an accurate MDS assessment for three of 29 vey sample, Resident # 9,			MDS staff and dieticians will be re-educated on ensuring that all residents are assessed and MDS codes correctly.		
		failed to correctly code ht on the quarterly MDS		F	RECEIVED		

(minimum data set) assessment with an ARD (assessment reference date) of 11/24/16.

2. a. The facility staff failed to correctly code

MAR 09 2017

ADH/OFC

PRINTED: 02/28/2017

		AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>MB NC</u>	<u>). 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		495045				02	C 2 <b>/15/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	CES-RICHMOND			5 HILLIARD ROAD CHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	<b>x</b> '	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	weight gain on the (MDS) assessment b. The facility staff of O of the 14 day MD assessment referenceiving oxygen the	ge 50 ving a weight loss instead of a 14 day minimum data set with an ARD date of 11/16/16. coded Resident #11, in section is assessment with an ince date of 11/16/16, as erapy. The resident did not ers for and was not receiving	F 2	78	Criteria 4  The administrator or designee waudit sections K, O and H of the MDS to ensure accurate assessment and coding daily x5 days, three times weekly x3 wee and monthly x2 months to ensure	eks	3/31/17

The findings include:

oxygen.

1. The facility staff failed to correctly code Resident # 9's height on the quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/24/16.

3. The facility staff failed to correctly code

Resident #12's continence status on the quarterly

MDS (minimum data set) assessment, with an assessment reference date of 12/24/16.

Resident # 9 was admitted to the facility on 02/23/11 and readmitted on 09/15/11 with diagnoses that included but were not limited to: hypertension (1), heart failure, umbilical hernia (2), dementia (3), gastroesophageal reflux disease (4) and gout (5).

Resident # 9's most recent comprehensive MDS (minimum data set) a significant change assessment, with an assessment reference date (ARD) of 01/23/17, coded the resident as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being moderately impaired of cognition for daily decision making. Resident # 9 was coded as requiring limited

RECEIVED

Criteria 5

The facility's alleged date of

compliance is 3/31/2017.

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		ATE SURVEY OMPLETED
		495045	B. WING			0	C <b>2/15/2017</b>
•	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-RICHMOND		21	TREET ADDRESS, CITY, STATE, ZIP CODE 125 HILLIARD ROAD ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 278	assistance of one s daily living. In Sec Status, under K020	age 51 staff member for activities of tion K: Swallowing/Nutritional 00: Height and Weight, ht was documented as 66	F2	<b>?78</b>			
	quarterly assessme coded the resident interview for menta - 15, 15 being cogr making. Resident limited assistance Section K: Swallow	S (minimum data set) a ent, with an ARD of 11/24/16 as scoring a 15 on the brief al status (BIMS) of a score of 0 nitively intact for daily decision # 9 was coded as requiring with activities of daily living. In ring/Nutritional Status, under Weight, Resident # 9's height s 68 inches.					
	conducted with RN coordinator regardi documentation of F significant change assessments abov on the quarterly MI height should have asked what guidan assessments, LPN	5 a.m. an interview was (registered nurse) # 4, MDS ng the discrepancy in Resident # 9's height on the and quarterly MDS e. RN # 4 stated, "The height DS was coded incorrectly. The been 66 inches." When ce they use to complete MDS # 4 stated, "We follow the RAI ent instrument) manual."					•
	(resident assessme Manual CH 3: MDS "K0200: Height and Weight (cont.) Item Quality of Life. Din hydration status ca	Medicare/Medicaid) RAI ent instrument) Version 3.0 Items [K] documented, I Weight. K0200: Height and I Rationale. Health-related ininished nutritional and I lead to debility that can alth and safety as well as		M	ECEIVED AR 0 9 2017 DHOLG		

quality of life. Planning for Care. Height and weight measurements assist staff with assessing

PRINTED: 02/28/2017 FORM APPROVED

		O MEDICAID CEDVICES					VLLICOAED
	CENTERS FOR MEDICARE & MEDICAID SERVICES				3	. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE		ONSTRUCTION	COM	E SURVEY IPLETED
		495045	B. WING	<u>}</u>		1	C / <b>15/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERV	ICES-RICHMOND		2125	HILLIARD ROAD		
WANORC	ARE NEALIN SERV	OCS-NOTHIOTES		RIC	HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	Continued From pa	ge 52	F:	278			
	the resident's nutrit	ion and hydration status by	:				
		nism for monitoring stability of	: :				
		d of time. The measurement ide for determining nutritional	. A planting of		•		
		ssessment for K0200A,	1				
		eight on the most recent height	* :				
		ent admission/entry or reentry. d height in inches. 2. Measure	÷				
		over time in accordance with	2				
	the facility policy an	nd procedure, which should					
		dards of practice (shoes off,					
		quent assessments, check the he last height recorded was					
		r ago, measure and record the	1				
	resident's height ag	gain. Coding Instructions for	-				
		lecord height to the nearest athematical rounding (i.e., if	:				
		nt is X.5 inches or greater,					
		d to the nearest whole inch. If	\$ \$				
		nt number is X.1 to X.4 inches,	1				
		nearest whole inch). For of 62.5 inches would be	ŧ				
		es and a height of 62.4 inches					
	would be rounded t						
	On 02/15/17 at app	roximately 2:00 p.m. ASM					
	(administrative staff						
		ASM # 2, the director of aware of the findings.					
	Ç,	· ·					
,		ion was provided prior to exit.		R	tility		
	References:			V	IAK 09 2017		
	(1) High blood pres obtained from the w	sure. This information was vebsite:		V.	DH/OLG		

essure.html.

https://www.nlm.nih.gov/medlineplus/highbloodpr

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NC	0. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
I	•	495045	B. WING	i			C 2/15/2017
	PROVIDER OR SUPPLIER			2125	EET ADDRESS, CITY, STATE, ZIP CODE 5 HILLIARD ROAD HMOND, VA 23228		110/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	(2) An umbilical her (protrusion) of the lithe abdominal orgathe belly button. The from the website: https://medlineplus.  (3) Dementia is a looccurs with certain of thinking, language, information was obtained from the esophagus and was obtained from the https://www.nlm.nih.  (5) A type of arthritis builds up in blood ar joints. This informativebsite: https://medlineplus.g.  2. a. The facility staff Resident #11 as have weight gain on the Aday assessment with reference date of 11.  Resident #11 was act 10/21/15 and was rediagnoses that inclu-	ernia is an outward bulging lining of the abdomen or part of an(s) through the area around his information was obtained agov/ency/article/000987.htm.  Doss of brain function that diseases. It affects memory, judgment, and behavior. This tained from the website: agov/ency/article/000739.htm.  Into to leak back, or reflux, into irritate it. This information the website: agov/medlineplus/gerd.html.  Sold in a cause inflammation in the ation was obtained from the ation was obtained from the adon was obtained from the altin was obtained from the altin was eight loss instead of a MDS (minimum data set), a 14 MDS (minimum da	manager on a community of	**************************************	ECEIVED MAR 0 9 2017 DH/OLG		

The most recent MDS, a 14 day assessment, with an ARD of 11/16/16 coded the resident as having a nine out of 15 on the BIMS indicating the

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

<u>IEDICARE</u>	& MEDICAID SERVICES	OMB NO. 0938-039					
NCIES TON	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,				DATE SURVEY COMPLETED	
	495045	B. WING				C <b>02/15/2017</b>	
R SUPPLIER				• • •			
LTH SERV	ICES-RICHMOND						
H DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE	
was model dent was co f for activit nich the res prepared. receiving nd Weight 159 pound "was doce ight loss d n K0310 W ted in the a weight ga of the MDS date of 11/9 eight and V weighing #11 was s	crately cognitively impaired. Incoded as needing assistance ties of daily living except for esident could do once the meal. In section O: the resident was a oxygen. In section K0200 the resident was coded as ds. In section K0300 Weight extracted in the box indicating did not occur or was unknown. Weight Gain a "2" was box indicating that the resident train.  So, an annual assessment, with 19/16 documented in section Weight that the resident was 166 pounds. This indicated seven pounds heavier than	At the control of the	:78	***************************************			
OSM (other When asked here weight assessment with an assessment with a with	ter staff member) #11, the ted who completed section K ments, OSM #11 stated, "We low weights were obtained to assessment, OSM #11 stated, its and my notes. I don't review ents." When asked to review ent #11's annual MDS in ARD of 11/9/16 and the 14 ent with an ARD of 11/16/16, Dkay, I see the issue. It looks weight was not accurate. The	-					
THE TAIL THE PROBLEM OF THE TRANSPORT OF THE POST OF T	R SUPPLIER  LTH SERV  UMMARY STATE A IDEFICIENCY ATORY OR LE  d From pa was mode dent was co f for activite nich the re- prepared. Freceiving nd Weight 159 pound was dock ight loss d n K0310 W ted in the a weight g f the MDS date of 11/8 eight and \( \) weighing #11 was s ted on the ent. iew was co OSM (oth When asked he MDS the weight as session asked he the MDS	A95045  R SUPPLIER  LTH SERVICES-RICHMOND  UMMARY STATEMENT OF DEFICIENCIES IDEFICIENCY MUST BE PRECEDED BY FULL. ATORY OR LSC IDENTIFYING INFORMATION)  d From page 54  was moderately cognitively impaired. Ident was coded as needing assistance of for activities of daily living except for nich the resident could do once the meal prepared. In section O: the resident was receiving oxygen. In section K0200 and Weight the resident was coded as 159 pounds. In section K0300 Weight "was documented in the box indicating light loss did not occur or was unknown. In K0310 Weight Gain a "2" was uted in the box indicating that the resident as weight gain.  If the MDS, an annual assessment, with late of 11/9/16 documented in section eight and Weight that the resident was weighing 166 pounds. This indicated #11 was seven pounds heavier than ted on the 11/16/16 14 day MDS ent.  Item was conducted on 2/15/17 at 9:50 OSM (other staff member) #11, the When asked who completed section K DS assessments, OSM #11 stated, "We in asked how weights were obtained to the MDS assessment, OSM #11 stated, the MDS assessment was assessment was assessment as the MDS	ASSESSMENTS. (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495045  B. WING  R SUPPLIER  LTH SERVICES-RICHMOND  UNMARY STATEMENT OF DEFICIENCIES IDEFICIENCY MUST BE PRECEDED BY FULL AATORY OR LSC IDENTIFYING INFORMATION)  d From page 54  Was moderately cognitively impaired. Ident was coded as needing assistance for activities of daily living except for high the resident could do once the meal prepared. In section O: the resident was receiving oxygen. In section K0300 Weight I'w was documented in the box indicating ight loss did not occur or was unknown. In K0310 Weight Gain a "2" was atted in the box indicating that the resident as weight gain.  If the MDS, an annual assessment, with late of 11/9/16 documented in section eight and Weight that the resident was weighing 166 pounds. This indicated #11 was seven pounds heavier than ted on the 11/16/16 14 day MDS ent.  If was conducted on 2/15/17 at 9:50  OSM (other staff member) #11, the When asked who completed section K DS assessments, OSM #11 stated, "We in asked how weights were obtained to the MDS assessment, OSM #11 stated, the weights and my notes. I don't review assessments." When asked to review on Resident #11's annual MDS ent with an ARD of 11/19/16 and the 14 assessment with an ARD of 11/16/16, stated, "Okay, I see the issue. It looks 66 pound weight was not accurate. The	ASSESSMENTS, OSM #11 stated, the weight and Weight that the resident was weighing 166 pounds. This indicated #11/9/16 and the MDS assessments. When asked who completed section K DS assessments. When asked how weights and my notes. I don't review assessment #11/s annual MDS ent with an ARD of 11/19/16 and the 14 assessment with an ARD of 11/19/16, stated, "Okay, I see the issue, It looks 6d to the deck the he weight and Weight wan ARD of 11/19/16, stated, "Okay, I see the issue, It looks 6d to the deck the he weight and Weight wan ARD of 11/19/16, stated, "Okay, I see the lissue, It looks 6d to the weight and weight and ARD of 11/19/16 and the 14 assessment with an ARD of 11/19/16, stated, "Okay, I see the issue, It looks 6d to the weight and weight wan acked why the other the weight and weight wan and my notes. It looks 6d be to the weight and weight wan and my notes. It looks 6d be to the weight and weight wan and my notes. It looks 6d be to the weight and weight wan and my notes. It looks 6d be to the weight and weight wan and my notes. It looks 6d to the weight and weight wan and my notes. It looks 6d to the weight and weight wan and my notes. It looks 6d to the weight and weight wan not accurate. The control of the weight and weight wan acked why the control of the weight and weight wan not accurate. The control of the weight and weight wan acked why the control of the weight and weight wan not accurate. The control of the weight and weight wan acked why the control of the weight and weight wan acked why the control of the weight and weight wan not accurate. The control of the weight and weight wan acked why the control of the weight and weight and weight wan acked why the control weight and weight wan acked why the control weight and weight want acked why the control of the weight and the weight and weight want acked why the control of the weight and weight and weight want acked why the control of the weight and weight want acked why the control of the weight and weight want acked why the control of the we	ASSUPPLIER  LTH SERVICES-RICHMOND  WINMARY STATEMENT OF DEFICIENCIES IDEPCIENCY MUST BE PRECEDED BY FILL ATORY OR LSC IDENTIFYING INFORMATION)  d From page 54  was moderately cognitively impaired. Ient was coded as needing assistance for activities of daily living except for nich the resident could do once the meal prepared. In section C0200 and Weight the resident was receiving oxygen. In section K0200 and Weight that the resident was receiving oxygen. In section K0300 Weight "was documented in the box indicating light loss did not occur or was unknown. In K0310 Weight Gain a "2" was ated in the box indicating light loss did not occur or was unknown. In K0310 Weight Gain a "2" was ated in the box indicating that the resident was weighting 166 pounds. This indicated #11 was seven pounds heavier than ted on the 11/16/16 14 day MDS ent.  sew was conducted on 2/15/17 at 9:50 OSM (other staff member) #11, the When asked who completed section K DS assessments, OSM #11 stated, the weights and my notes. I don't review assessments." When asked how weights were obtained to the MDS assessment, COSM #11 stated, the weights and my notes. I don't review assessments." When asked how weight was not accurate. The details and the property of t	ASSESSMENT, STATE THE PROCESS CITY, STATE, ZIP CODE  2(22) MULTIPLE CONSTRUCTION A BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  2125 HILLIARD ROAD RICHMOND, VA 23228  ID PROVIDER'S PLAN OF CORRECTION BEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)  IDENTIFY INFORMATION	

resident was coded as having a weight gain instead of the seven pound weight loss as documented, OSM #11 did not have an

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>IMB NC</u>	<u>). 0938-039</u>
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495045	B. WING		***	02	C 2/15/2017
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-RICHMOND				2	TREET ADDRESS, CITY, STATE, ZIP CODE 125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 278	explanation. When used to complete the #11 stated, "The R/instrument)."  On 2/15/17 at 2:03 member) #1, the additional member in the state of the st	ge 55 asked what reference they ne MDS assessment, OSM AI (resident assessment  p.m. ASM (administrative staff imministrator and ASM #2, the were made aware of the	F 2	<b>:78</b>			

b. The facility staff coded Resident #11, in section O of the 14 day MDS assessment with an ARD of 11/16/16, as receiving oxygen therapy. The resident did not have physician orders for and

No further information was provided prior to exit.

was not receiving oxygen.

An observation of Resident #11 was made on 2/14/17 at 2:30 p.m., Resident #11 was sitting on the side of the bed. The resident was not wearing oxygen and there was no oxygen in the room.

An observation was made of Resident #11 on 2/15/17 at 7:30 a.m., Resident #11 was walking around the room. There was no oxygen observed in the room.

Review of the physician's orders dated and signed on 1/28/17 did not evidence documentation regarding an oxygen order.

Review of the November and December 2016 TARs (treatment administration records) and the January 2017 TAR did not evidence documentation regarding oxygen.

RECEIVED

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	: & MEDICAID SERVICES			OMR M	<u>U. 0938-0391</u>		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUI A. BUIL.	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
			2 14/15/0	,		С		
		495045	B. WING		0	2/15/2017		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
MANORO	CARE HEALTH SERV	ICES-RICHMOND		2125 HILLIARD ROAD RICHMOND, VA 23228				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 278	Continued From na	ige 56	E ·	278				

An interview was conducted on 2/15/17 at 9:40 a.m. with RN (registered nurse) #6, the MDS coordinator. When asked how information was obtained to complete the MDS assessments, RN #6 stated the information was located in the clinical record or through resident interview. When asked to review Resident #11's 14 day MDS assessment with an ARD of 11/16/16, that coded Resident #11 as receiving oxygen, RN #6 stated, "I don't see it in the notes. It might have been a coding error. Why I went back and checked it I don't know." When asked what document they used to complete the MDS assessments, RN #6 stated, "The RAI."

On 2/15/17 at 2:03 p.m. ASM #1 and ASM #2 were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to correctly code Resident #12's continence status on the quarterly MDS (minimum data set) assessment, with an assessment reference date of 12/24/16.

Resident #12 was admitted to the facility on 6/21/15 with diagnoses that included but were not limited to: bladder cancer, chronic obstructive pulmonary disease (COPD), cataracts, and has a pacemaker (an electrical device used to maintain a normal heart rhythm (1)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 12/24/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring supervision, or as independent for all of his activities of daily living. In Section H - Bladder

RECEIVED

MAR 0 9 2017

VDH/OLC

PRINTED: 02/28/2017

DELLARIMENT	/	WAS LIGINIVIA OFMAIOFO				FORM A	<b>APPROVED</b>
CENTERS FOR	MEDICARE	& MEDICAID SERVICES			C	MB NO.	0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUI A. BUILC		ONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495045	B. WING			1	, 5/2017
NAME OF PROVIDER	OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		0,201,
MANORCARE HEA	ALTH SERVI	CES-RICHMOND			HILLIARD ROAD HMOND, VA 23228		
PREFIX (EAC	H DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278 Continu	ed From pa	ge 57	F 2	278			
and Bov	vel, Resider	nt #12 was coded as having an					İ
		procedure in which an opening					
		passage of urine from the mithe mithe mithe intestines (2)). In					
		nary Continence, the resident					
		" indicating the resident was					
always o	continent.						
9/24/16, quarterly 12/24/16 an ARD an ostor Contine indicatin (indwelli	was review / assessme 5. The quar of 9/24/16, ny. In Sectionce, the res g "not rated ng or condo	assessment, with an ARD of red and compared to the nt with an ARD date of terly MDS assessment, with coded the resident as having on H0300 - Urinary ident was coded with a "9" in resident had a catheter om), urinary ostomy or no entire 7 days."					
a.m. with nurse. F quarterly 9/24/16: wrong (c of 12/24 section b continent diversion	n RN (regist RN #4 was a MDS asse and 12/24/1 juarterly ME (16 coding t H0300). It s t, he has ar n is a surgic	ered nurse) #4, the MDS asked to review the two ssments, with an ARD of 6. RN #4 stated, "That's DS assessment with and ARD he resident as continent in should not be coded as i lleal conduit (Urinary al procedure that reroutes the					
		out of the body when urine That's my fault, I coded that			MELLE VENER		

p.m.

The administrator, the director of nursing, and the corporate quality assurance nurse were made aware of the above findings on 2/15/17 at 2:00

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	49 LOV MEDICALE	A MEDICAID SERVICES		_		<del>1417-147</del>	<del>/. 0000 000 i</del>		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
							С		
		495045	B. WING			02	/15/2017		
• • • • • • • • • • • • • • • • • • • •	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-RICHMOND		21	FREET ADDRESS, CITY, STATE, ZIP CODE 125 HILLIARD ROAD ICHMOND, VA 23228				
	0. 11 D 14 D 1 O T	TOURIST OF OFFICIENCIES		110	PROVIDER'S PLAN OF CORRECTIO	A.	· WE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	COMPLETION DATE		
F 278	Continued From pa	ge 58	F2	278					
F 279	Non-Medical Read Chapman; page 42 (2) Barron's Diction Non-Medical Read Chapman; page 42 (3) This information following website:	eary of Medical Terms for the er 5th edition, Rothenberg and 4 a was obtained from the hih.gov/health-information/urolary-diversion.	F.	279			3/31/17		
SS=D	COMPREHENSIVE	CARE PLANS			F-279		3/31/11		
	assessments components in the resideresults of the assess and revise the residual.	nust maintain all resident bleted within the previous 15 ent's active record and use the ssments to develop, review dent's comprehensive care			It is the intended practice of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet resident's medical, nursing, and mental and psychosocial needs that are identified in the	ch le t a d			
	483.21 (b) Comprehensive	Care Plane			comprehensive assessment.				
	(1) The facility must comprehensive per each resident, consist forth at §483.10 includes measurab to meet a resident's and psychosocial measurab	t develop and implement a reson-centered care plan for sistent with the resident rights 0(c)(2) and §483.10(c)(3), that le objectives and timeframes a medical, nursing, and mental eeds that are identified in the	1		Criteria 1 Upon notification from surveyor Resident#1's care plan was reviewed and up dated to reflect cognitive loss/dementia status				
		ehensive assessment. The comprehensive lan must describe the following -			RECEIVED				
	(i) The services tha	t are to be furnished to attain		N	MAR 0 9 2017				
	or maintain the res	dent's highest practicable							

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495045	B. WING _		C 02/15/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MANOR	CARE HEALTH SERVI	CES-RICHMOND		2125 HILLIARD ROAD RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 279	physical, mental, ar	ige 59 nd psychosocial well-being as 3.24, §483.25 or §483.40; and	F 27	79 <u>Criteria 2</u> All residents have a potential to affected.	3/31/17 be
	under §483.24, §48 provided due to the under §483.10, inclutreatment under §48 (iii) Any specialized	services or specialized es the nursing facility will		Criteria 3  MDS and social service staff w be re-educated to develop comprehensive care plans from triggered areas in the care area assessment.	
	recommendations. findings of the PAS/ rationale in the residual (iv) in consultation we resident's represent	If a facility disagrees with the ARR, it must indicate its dent's medical record.		Criteria 4  The administrator or designee valudit section V of MDS to ensure comprehensive assessments have been developed for these trigger items dailyx5 days, three times weekly x3 weeks and monthly months	ire ve red
	future discharge. Fa whether the residen community was ass	preference and potential for acilities must document acilities must document at's desire to return to the sessed and any referrals to lies and/or other appropriate pose.		Criteria 5  The facility's alleged date of compliance is 3/31/2017.	
	plan, as appropriate requirements set for section.	s in the comprehensive care e, in accordance with the rth in paragraph (c) of this		RECEIVED	

Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan from triggered areas in the CAA (care

by:

MAR 09 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	<u>RS FOR MEDICARE</u>	E & MEDICAID SERVICES				OMB NO	<u>0. 0938-0391</u>
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495045	B. WING	;	· Account of the Acco	0:	C 2/15/2017
NAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
REANIOD(	CARE DEALTH CERV	TODE DICUMOND	-	2125	HILLIARD ROAD		
WANON	CARE HEALTH SERVI	ICES-RICHIWIOND		RICH	IMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 60	F2	279			
	•	section of the MDS (minimum	ē				
		ent for one of 29 residents in					
	The facility staff fail	led to develop Resident #1's					·
		AA triggered area of cognitive					
		ection V of the admission MDS	;				
		n ARD (assessment reference					
	The findings include	e:					•
	Resident #1 was ac	dmitted to the facility on	-				
	10/21/16. Resident	t #1's diagnoses included but	-				
		pressure ulcer (1), major					
		r and diabetes. Resident #1's					
		a quarterly assessment with an reference date) of 1/15/17,	:				
		s cognition as being severely	÷				
	impaired.	2 00g					
		recent comprehensive MDS	1				
		assessment with an ARD of					
	10/28/16. Section \						
		nented an "X" beside the of cognitive loss/dementia					·
		e area would be care planned.					
		orehensive care plan initiated					
		o document any information					
	regarding cognitive	loss/dementia.					
	0 - 04547 - 10.05			F	RECEIVED		
		a.m., an interview was (registered nurse) #5 (MDS		-	Without Tank Botton S W Earner Market		
					MAR 0 9 2017		1
	•	oordinator). RN #5 was asked to review tesident #1's comprehensive care plan and show			<del> </del>		
	this surveyor where	cognition had been care plan. RN #5 reviewed		•	VDH/OLG		

Resident #1's comprehensive care plan and confirmed cognition was not documented on the

PRINTED: 02/28/2017 FORM APPROVED

CENIER	KS FOR MEDICARE	& MEDICAID SERVICES				CIMP INC	<i>).</i>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495045	B. WING			02	C 2/15/2017
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
*****	ADELICALTH COM	ICES DICUMOND	,	212	5 HILLIARD ROAD		
MANORC	CARE HEALTH SERV	ICES-RICHWOND		RIC	HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	CAAs and are docuplanned should be she writes all the trichecks the areas o #5 stated she would #1's care plan on the references the CMS Medicaid Services)	age 61 stated areas that trigger on the amented as needing to be care care planned. RN #5 stated aggered areas on a form then ff as she care plans them. RN d add cognition to Resident his day. RN #5 stated she S (Centers for Medicare & RAI (Resident Assessment I when care planning based on		279			
	staff member) #1 (Ithe director of nursabove concern.  The CMS RAI man "Coding Instruction Facility staff are to mechanism to deterequire review and triggered care area "Care Area Triggere each triggered care and current standar or expert-endorsed resources to conducare area. Docume	p.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the ual documented the following: s for V0200A, CAAs use the RAI triggering rmine which care areas additional assessment. The s are checked in Column A ed" in the CAAs section. For a area, use the CAA process rd of practice, evidence-based clinical guidelines and act further assessment of the ent relevant assessment ing the resident's status.					
	Chapter 4 of this minstructions on the and documentation. For each triggered Planning Decision new care plan, care of the current care	anual provides detailed CAA process, care planning,	:		RECEIVED MAR 0 9 2017 VDH/OLG		·

the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CLIVILI	VO I OK MEDIOVITE	L & MILDIOAID OLIVIOLO	<del></del>			IND NO.	0930-0391
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COMP	E SURVEY PLETED
		495045	B. WING	***************************************	***************************************	02/1	C 15/2017
NAME OF I	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		. •
				217	25 HILLIARD ROAD		
MANORU	CARE HEALTH SERV	ICES-RICHMOND		RIC	CHMOND, VA 23228		
(VA) ID	SUMMARY ST/	ATEMENT OF DEFICIENCIES	<u>I</u>	<del></del>	PROVIDER'S PLAN OF CORRECTIO		20092
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 62	F2	79			
		within 7 days of completing					
		ed by the date in V0200C2,					
		nat the care planning					
		ompleted and that the					
	resident's care plan				·		
	No further informati	ion was presented prior to exit.	2				
		ıry (pressure ulcer) is localized	1				
		and underlying soft tissue	-				:
		prominence or related to a	•				
		evice. The injury can present					
		open ulcer and may be					
		occurs as a result of intense ressure or pressure in	-		RECEIVED		,
		ressure or pressure in hear. The tolerance of soft			The survey of the state of the survey of the		
		and shear may also be			MAR 09 2017		
		imate, nutrition, perfusion,					
	co-morbidities and	condition of the soft tissue."	:		VDH/QLG		
		as obtained from the website:					
		rg/resources/educational-and-					
		puap-pressure-injury-stages/	•				
		)(3),483.21(b)(2) RIGHT TO	F 2	80 n			2/21/12
SS=D	PARTICIPATE PLAI	NNING CARE-REVISE CP			F-280		3/31/17
	483.10				It is the intended practice of thi	is	
		participate in the development			facility to honor a resident's rig	ht	
		of his or her person-centered	•		to—unless adjudged incompeter		
	plan of care, includi	ing but not limited to:			or otherwise found to be	•	
	203 MM			,		.r	
		cipate in the planning process,			incapacitated under the laws o	-	
		o identify individuals or roles to	,		the state—participate in planning		
		planning process, the right to			care and treatment or changes	in	ļ
		nd the right to request			care and treatment.		
	revisions to the pers	son-centered plan of care.					
	(ii) The right to parti	icipate in establishing the					

expected goals and outcomes of care, the type,

					PRINTED	: 02/28/2017
DEPART	MENT OF HEALTH	AND HUMAN SERVICES		Marine Ma		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION			PLE CONSTRUCTION  IG		E SURVEY MPLETED
		495045	B. WING_		E .	C / <b>15/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	CES-RICHMOND		2125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ILD BE	(X5) COMPLETION DATE
				1		3/31/17
F 280	Continued From pa	ge 63	F 28	Criteria 1		
	amount, frequency,	and duration of care, and any d to the effectiveness of the		Upon notification from survey Resident #8's indwelling uring eatheter was taken off the care	ary	
	(iv) The right to recincluded in the plan	eive the services and/or items of care.		plan and Resident #11's oxygouse was resolved off the care p	en plan.	₹
		the care plan, including the gnificant changes to the plan		Criteria 2  Any and all residents have the potential to be affected.	;	
	right to participate i	nall inform the resident of the n his or her treatment and sident in this right. The nust		<u>Criteria 3</u> The interdisciplinary team w		
	(i) Eacilitate the incl	usion of the resident and/or		re-educated to ensure that car	re	

- resident representative.
- (ii) Include an assessment of the resident's strengths and needs.
- (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

- (b) Comprehensive Care Plans
- (2) A comprehensive care plan must be-
- (i) Developed within 7 days after completion of the comprehensive assessment.
- (ii) Prepared by an interdisciplinary team, that includes but is not limited to--
- (A) The attending physician.

plans are updated to reflect residents' current status.

#### Criteria 4

DON or designee will audit care plan via ER to ensure care plans are updated timely to reflect residents' current conditions daily x5days, 3 times weekly x3 weeks, and monthly x2 months.

Criteria 5 The facility's alleged date of compliance is 3/31/2017.

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

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 64 of 134

RECEIVED

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495045	B. WING			02	C /15/2017
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-RICHMOND		2125	EET ADDRESS, CITY, STATE, ZIP CODE 5 HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	resident.	ge 64 rse with responsibility for the th responsibility for the	F2	:80			
	(D) A member of for (E) To the extent prother resident and the An explanation must medical record if the and their resident resident resident resident.	od and nutrition services staff.  acticable, the participation of e resident's representative(s). It be included in a resident's e participation of the resident epresentative is determined the development of the	• 11.1 (778)00,654				
	disciplines as deternor as requested by (iii) Reviewed and reteam after each ass comprehensive and assessments. This REQUIREMEN	evised by the interdisciplinary sessment, including both the					
	document review ar was determined that and revise the compof 29 residents in that and Resident #11.  1. The facility staff for the staff of the staf	ion, staff interviews, facility and clinical record review, it at facility staff failed to review brehensive care plan for two be survey sample, Resident #8 alled to revise Resident #8's be plan after the urinary			RECEIVED  MAR 0 9 2017		
	catheter was discor				<b>VDH/OLG</b>		

2. The facility staff failed to revise Resident #11's comprehensive care plan after oxygen was

PRINTED: 02/28/2017 FORM APPROVED

CENTE	RS FUR MEDICARE	E & MEDICAID SERVICES			OIVID IVC	<i>.</i> <del>0930-039</del>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED	
						С
		495045	B. WING		02	/15/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
MANOR	CARE HEALTH SERV	ICES-RICHMOND		2125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
E 200	Continued From po			; ;		

280 Continued From page 65 discontinued on 11/3/16.

The findings include:

1. The facility staff failed to revise Resident #8's comprehensive care plan after the urinary catheter was discontinued on 2/2/17.

Resident #8 was admitted to the facility on 3/25/11 and readmitted on 12/24/16 with diagnoses that included but were not limited to: urinary incontinence, kidney disease, anemia, dementia and diabetes.

The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 11/18/16 coded the resident as having scored 10 out of 15 on the brief interview for mental status (BIMS) assessment indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as always being incontinent of urine.

An observation of Resident #8 was made on 2/14/16 at 2:35 p.m.; the resident was lying in bed watching television there was no urinary catheter seen.

An observation was made of Resident #8 on 2/15/16 at 7:20 a.m. and 9:15 a.m.; Resident #8 was awake and resting in bed. There was no urinary catheter observed.

Review of Resident #8's comprehensive care plan initiated on 12/25/16 documented, "Focus Use of indwelling catheter needed until seen by RECEIVED

MAR 09 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	·		<u>ON</u>	MB NO. 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495045	B. WING			C <b>02/15/2017</b>
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	ICES-RICHMOND		STREET ADDRESS, CITY 2125 HILLIARD ROAD RICHMOND, VA 232		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD I NCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 280	amount and color, of Review of the 1/30/evidence document the urinary catheter.  Review of the physical documented, "Claric (discontinue) Foley.  Review of the Janual administration record Catheter care qs (ecare was document 1/4/16 through 1/31.  Review of the Februevidence document catheter.  An interview was coal	ions Report any changes in or odor of urine."  /17 urologist note did not tation regarding the status of r.  ician's orders dated 2/2/17 ification order: DC Cath (catheter)"  lary 2017 TAR (treatment ord) documented, "Foley every shift)." Urinary catheter ted as being provided from 1/16."  uary 2017 TAR did not tation regarding the urinary  onducted on 2/15/17 at 9:40 of the ere	F 2	80		
	a.m. with RN #3, the who used the care presented uses the asked when a residupdated. RN #3 sta	producted on 2/15/17 at 10:46 the unit manager. When asked plan, RN #3 stated, the care plan." RN #3 was blent care plan would be ated, "Care plans are updated s, when orders change or the		RECEIVED MAR 0 9 2017 VDH/OLC		

condition changes. So could be (updated) by any of the nurses." When asked why the care plans

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		40.50 f.F	n was					С
		495045	B. WING				02/	/15/2017
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-RICHMOND		21	TREET ADDRESS, CITY, STATE, Z 125 HILLIARD ROAD RICHMOND, VA 23228	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TON SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 280	conditions change scare on an ongoing care plan would be urinary catheter ren  An interview was county asked to review Restated, "So no it's new When asked if the county and the county and the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "It has a county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "It has a county asked to review Restated, "So no it's new When asked if the county asked to review Restated, "It has a county asked to review Restated, "It has a county asked to review Restated, "It has a county asked to review Restated, "It has a county asked to review Restated, "It has a county asked to review Restated, "It has a county asked to review Restated, "It has a county asked to review Restated, "It has a county asked to review Restated, "It has a county asked to review Restated, "It has a county asked to review Restated, "It has a county asked to revie	RN #3 stated, "As (resident) so we can deliver appropriate basis." When asked if the updated if a resident had a noved, RN #3 stated, "Yes." anducted on 2/15/17 with RN think that (the urinary ed from the care plan." When sident #8's care plan, RN #7 for resolved. I was wrong." care plan should have been ted, "Yes."	F 2	80				
	also identifies the ty the patient should re COMPONENTS: Ex patients' progress to	pes and methods of care that eceive. CARE PLAN valuating means monitoring oward their goals. Evaluation ting treatment plans or		1	RECEIVED			
		on was provided prior to exit.		•	MAR 0 9 2017			
	Williams and Wilkin documented, "A write	mentals of Nursing Lippincott s 2007 pages 65-77 ten care plan serves as a among health care team			VDH/OLG			

members that helps ensure continuity of

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				<u> DMR N</u>	IO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION		OATE SURVEY COMPLETED
		495045	B. WING	3_			C )2/15/2017
NAME OF F	PROVIDER OR SUPPLIER			Π	STREET ADDRESS, CITY, STATE, ZIP CODE		
******	SADE HEALTH CEDV	ioce piculionip	!		2125 HILLIARD ROAD		
MANURU	CARE HEALTH SERVI	CES-KICHMOND			RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ΞIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	Continued From pa	age 68	F:	280	) )		
	· ·	care plan is a vital source of	•				!
	information about the	he patient's problems, needs,	•				ļ
		ins detailed instructions for					
		s established for the patient careexpect to review,					
		the care plan regularly, when					
		in condition, treatments, and					
	with new orders"	(1)					,
		of Nursing Lippincott Williams pincott Company Philadelphia					The state of the s
	(Potter and Perry, 2 reference for care paymitten guideline for promoting continuity criteria to be used it care. The written conursing care prioritip professionals. The coordinates resource care. A correctly for easy to continue cat the patient's statu nursing diagnosis and longer appropriation. An out of date	entials for Practice, 6th edition, 2007, pages 119-127), was a plans. "A nursing care plan is for coordinating nursing care, by of care and listing outcome in the evaluation of nursing care plan communicates ies to other health care care plan also identifies and ces used to deliver nursing ormulated care plan makes it are from one nurse to another. It is has changed and the and related interventions are ate, modify the nursing care e or incorrect care plan quality of nursing care."	The second secon		RECEIVED		
	2 The facility staff t	failed to revise Resident #11's			MAR 0 9 2017		
	comprehensive care	e plan after the oxygen was					
	discontinued on 11/				VDH/CLC		:
	Resident #11 was a	admitted to the facility on					

10/21/15 and was readmitted on 11/3/16 with diagnoses that included but were not limited to:

PRINTED: 02/28/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0391					
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495045	B. WING			C 02/15/2017		
	PROVIDER OR SUPPLIER  CARE HEALTH SERVI	CES-RICHMOND		STREET ADDRESS, CITY, STATE, ZIP C 2125 HILLIARD ROAD RICHMOND, VA 23228	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 280	blood pressure and	e, irregular heartbeat, high	F 2	80				
	with an (assessmer 11/16/16 coded the nine out of 15 on th was moderately cog resident was coded staff for activities of which the resident of	nt reference date) ARD of resident as having scored a e BIMS, indicating the resident gnitively impaired. The as needing assistance from daily living except for eating could do once the meal tray resident was coded as	•					
	2/14/17 at 2:30 p.m the side of the bed.	tesident #11 was made on .; Resident #11 was sitting on The resident was not wearing as no oxygen in the room.						
·	2/15/17 at 7:30 a.m	lesident #11 was made on .; Resident #11 was walking here was no oxygen observed						
	Review of the physisigned on 1/28/17 of documentation of a							
	TARs (treatment ad		:	RECEIVED				
	10/2/15 and revised	#11's care plan initiated on on 12/2/15 documented, ease related to Hx (history) of		MAR 0 9 2017 <b>VDH/OLG</b>				

attack)....Interventions Administer oxygen as

MI (myocardial infarction, heart

PRINTED: 02/28/2017 FORM APPROVED

	& MEDICAID SEKVICES					<u> </u>
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	СОМ	E SURVEY IPLETED
	495045	B. WING			i .	15/2017
	CES-RICHMOND		2125	HILLIARD ROAD		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
•	=	F 2	280			
p.m. with LPN (licer resident's nurse. W an order for oxygen had oxygen in a lon was d/c'd (discontin the order, LPN #7 v asked if oxygen wa would be ordered a any medicine, LPN if the care plan wou	nsed practical nurse) #7, the hen asked if Resident #11 had a, LPN #7 stated, "He hasn't g time. I'm thinking that order sued)." When asked to locate was unable to do so. When s considered a medication and and discontinued the same as #7 stated, "Yes." When asked and be updated if the oxygen					
p.m. with ASM (adn the director of nursi Resident #11) had a oxygen when he wa until he went to the wasn't re-ordered w was asked when a updated. ASM #2 s changes in conditio baseline." When as plan should be updated.	ninistrative staff member) #2, ng. ASM #2 stated, "(Name of an order for prn (as needed) as admitted in February 2016 hospital in November. It when he came back." ASM #2 resident care plan would be stated, "We update any n, any deviation from the ked if Resident #11's care ated to reflect the			RECEIVED MAR 0 9 2017 VDH/OLG		
483.21(b)(3)(i) SER	VICES PROVIDED MEET	F 2	.81 /	F-281	,	3/31/17
(b)(3) Comprehensi	ed or arranged by the facility,		(	facility to provide services the meet professional standards o	ıt	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L.  Continued From particle of the continued of	A95045  PROVIDER OR SUPPLIER  RCARE HEALTH SERVICES-RICHMOND  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 70 ordered, monitor o2 (oxygen) sats (saturations) every shift."  An interview was conducted on 2/15/17 at 2:45 p.m. with LPN (licensed practical nurse) #7, the resident's nurse. When asked if Resident #11 had an order for oxygen, LPN #7 stated, "He hasn't had oxygen in a long time. I'm thinking that order was d/c'd (discontinued)." When asked to locate the order, LPN #7 was unable to do so. When asked if oxygen was considered a medication and would be ordered and discontinued the same as any medicine, LPN #7 stated, "Yes." When asked if the care plan would be updated if the oxygen had been discontinued, LPN #7 stated, "Yes."  An interview was conducted on 2/15/17 at 3:20 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated, "(Name of Resident #11) had an order for prn (as needed) oxygen when he was admitted in February 2016 until he went to the hospital in November. It wasn't re-ordered when he came back." ASM #2 was asked when a resident care plan would be updated. ASM #2 stated, "We update any changes in condition, any deviation from the baseline." When asked if Resident #11's care plan should be updated to reflect the discontinuation of oxygen, ASM #2 stated, "Yes."  No further information was provided prior to exit. 483.21(b)(3)(i) SERVICES PROVIDED MEET	PROVIDER OR SUPPLIER  CARE HEALTH SERVICES-RICHMOND  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 70 ordered, monitor o2 (oxygen) sats (saturations) every shift."  An interview was conducted on 2/15/17 at 2:45 p.m. with LPN (licensed practical nurse) #7, the resident's nurse. When asked if Resident #11 had an order for oxygen, LPN #7 stated, "He hasn't had oxygen in a long time. I'm thinking that order was d/c'd (discontinued)." When asked to locate the order, LPN #7 was unable to do so. When asked if oxygen was considered a medication and would be ordered and discontinued the same as any medicine, LPN #7 stated, "Yes." When asked if the care plan would be updated if the oxygen had been discontinued, LPN #7 stated, "Yes."  An interview was conducted on 2/15/17 at 3:20 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated, "(Name of Resident #11) had an order for prn (as needed) oxygen when he was admitted in February 2016 until he went to the hospital in November. It wasn't re-ordered when he came back." ASM #2 was asked when a resident care plan would be updated. ASM #2 stated, "We update any changes in condition, any deviation from the baseline." When asked if Resident #11's care plan should be updated to reflect the discontinuation of oxygen, ASM #2 stated, "Yes."  No further information was provided prior to exit. 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  (b)(3) Comprehensive Care Plans  The services provided or arranged by the facility,	PROVIDER OR SUPPLIER  CARE HEALTH SERVICES-RICHMOND  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 70  ordered, monitor o2 (oxygen) sats (saturations) every shift."  An interview was conducted on 2/15/17 at 2:45 p.m. with LPN (licensed practical nurse) #7, the resident's nurse. When asked if Resident #11 had an order for oxygen, LPN #7 stated, "He hasn't had oxygen in a long time. I'm thinking that order was d/c'd (discontinued)." When asked to locate the order, LPN #7 was unable to do so. When asked if oxygen was considered a medication and would be ordered and discontinued the same as any medicine, LPN #7 stated, "Yes." When asked if the care plan would be updated if the oxygen had been discontinued, LPN #7 stated, "Yes."  An interview was conducted on 2/15/17 at 3:20 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated, "(Name of Resident #11) had an order for prn (as needed) oxygen when he was admitted in February 2016 until he went to the hospital in November. It wasn't re-ordered when he came back." ASM #2 was asked when a resident care plan would be updated. ASM #2 stated, "We update any changes in condition, any deviation from the baseline." When asked if Resident #11's care plan should be updated to reflect the discontinuation of oxygen, ASM #2 stated, "Yes."  No further information was provided prior to exit. 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility,	DENTIFICATION NUMBER:  495045  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA. 23228  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY WIS THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 70  Continued From page 70 ordered, monitor o2 (oxygen) sats (saturations) every shift."  An interview was conducted on 2/15/17 at 2:45 p.m. with LPN (licensed practical nurse) #7, the resident's nurse. When asked if Resident #11 had an order for oxygen, LPN #7 stated, "He hasn't had oxygen in a long time. I'm thinking that order was dic'd (discontinued)." When asked to locate the order, LPN #7 was unable to do so. When asked if oxygen was considered a medication and would be ordered and discontinued the same as any medicine, LPN #7 stated, "Yes." When asked to locate the order plan would be updated if the oxygen had been discontinued, LPN #7 stated, "Yes."  An interview was conducted on 2/15/17 at 3:20 p.m. with ASM (administrative staff member) #2, the director of rursing, ASM #2 stated, "Name of Resident #11) had an order for prn (as needed) oxygen when he was admitted in February 2016 until he went to the hospital in November. It wasn't re-ordered when he came back." ASM #2 stated, "Name of Resident #11) had an order for prn (as needed) oxygen when he was admitted in February 2016 until he went to the hospital in November. It wasn't re-ordered when he came back." ASM #2 stated, "Name of Resident #11's care plan should be updated to reflect the discontinuation of oxygen, ASM #2 stated, "Yes."  No further information was provided prior to exit. 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility, to provide services the meet professional standards of the control of the provides and the professional standards of the control of the provides and the professional standards of the provides and the professional standards of the provides and the professional standards of the provides and the professional	DENTIFICATION NUMBER  495045  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  2125 HILLIARD ROAD  RICHMOND, VA 23228  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 70  ordered, monitor o2 (oxygen) sats (saturations) every shift."  An interview was conducted on 2/15/17 at 2:45 p.m. with LPN (licensed practical nurse) #7, the resident's nurse. When asked if Resident #11 had an order for oxygen, LPN #7 stated, "the hasn't had oxygen in a long time. I'm thinking that order was d/c'd (discontinued)." When asked to locate the order, LPN #7 was unable to do so. When saked if oxygen was considered a medication and would be ordered and discontinued the same as any medicine, LPN #7 stated, "Yes."  An interview was conducted on 2/15/17 at 3:20 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated, "Yes."  An interview was conducted on 2/15/17 at 3:20 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated, "Yes."  An interview was conducted on 2/15/17 at 3:20 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated, "Yes."  An interview was conducted to nurse have a saked when a resident care plan would be updated. ASM #2 stated, "Yes."  An interview was conducted to nurse have a state of the oxygen had been discontinued, LPN #7 stated, "Yes."  An interview was conducted to nurse have a saked if the care plan would be updated to fine oxygen, ask #2 stated, "Yes."  An interview was conducted to nurse have a state of the oxygen had been discontinued, LPN #7 stated, "Yes."  An interview was conducted to nurse have a saked if the care plan would be updated to fine oxygen, ask #2 stated, "Yes."  An interview was conducted to nurse have a saked if the care plan would be updated to fine oxygen, ask #2 stated, "Yes."  An interview was conducted to nurse have a saked if the care plan would be updated to fine oxygen, ask #2 stated, "Yes."  An inte

		AND HUMAN SERVICES				FOR	): 02/28/2017 MAPPROVED	
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		495045	B. WING			02	C 2/15/2017	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 25 HILLIARD ROAD			
MANORCARE HEALTH SERVICES-RICHMOND					CHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 281	(i) Meet profession: This REQUIREMED by: Based on observat document review a was determined that follow professional	age 71  al standards of quality.  NT is not met as evidenced tion, staff interview, facility and clinical record review, it at the facility staff failed to standards of practice for three the survey sample, Residents	F 2	281	Criteria 1 The Foley orders for residents # have been transcribed correctly TARS. Resident #12 Tylenol order was clarified and order for headache obtained. Resident #14's MD was notified and orders clarified and transcribed correctly on TARs.	il on r	3/31/17	
1	#1, #14, and #12.				Criteria 2			

- 1. The facility staff failed to accurately transcribe a physician's order to change Resident #1's Foley catheter as needed onto the December 2016 and January 2017 TARs (treatment administration record). The TARs documented to change the catheter every month on the 25th and as needed.
- 2. The facility staff failed to clarify physician's orders for nystatin cream and triamcinolone cream during the monthly order recapitulation reviewed by a facility nurse on 1/29/17 and signed by the nurse practitioner on 1/31/17, for Resident #14.
- 3. The facility staff failed to document a verbal telephone order and transcribe the order onto the MAR (medication administration record) for Resident #12.

The findings include:

1. The facility staff failed to accurately transcribe a physician's order to change Resident #1's Foley catheter (1) as needed onto the December 2016 and January 2017 TARs (treatment administration

Any and all residents have the potential to be affected.

Criteria 3

All licensed nurses will be reeducated on accurate transcription,

clarification and accuracy of monthly recapitulation.

Criteria 4

DON or designee will audit MD orders daily x5 days, three times weekly x3 weeks and monthly x2 months and 5 POC with monthly x3 months.

Criteria 5

The facility's alleged date of compliance is 3/31/2017.

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

Event ID: ODYV11

Facility ID: VA0241
RECEIVED

If continuation sheet Page 72 of 134

MAR 0 9 2017



PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NC	0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		TE SURVEY MPLETED
	•	495045	B. WING			02	C 2/15/2017
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	<del></del>
MANOR	CARE HEALTH SERVI	ICES-RICHMOND			25 HILLIARD ROAD CHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG	<b>(</b>	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	Continued From pa	ige 72	F 2	81			
		documented to change the ath on the 25th and as needed.					
•	10/21/16. Resident were not limited to: depressive disorder most recent MDS (r assessment with an	dmitted to the facility on t #1's diagnoses included but pressure ulcer (2), major r and diabetes. Resident #1's minimum data set), a quarterly n ARD (assessment reference aded the resident's cognition mpaired.	Transfer on these as				
	physician's telephor signed by the physic documented, "Change f PRN- monthly on 25 (diagnosis): wound Resident #1's clinica physician's order su that documented, "C	t #1's clinical record revealed a ne order dated 11/29/16 and cian on 11/30/16 that nge Foley catheter today Foley catheter monthly and 5th of every month. DX healing." Further review of al record revealed a ummary signed on 11/30/16 CHANGE FOLEY CATH ench [size]) AS NEEDED 11-7 a.m. shift)."					
	administration recor Foley catheter on th Resident #1's Janua "CHANGE FOLEY O AND AS NEEDED O	ember 2016 TAR (treatment rd) documented, "Change ne 25th & PRN (as needed)." ary 2017 TAR documented, CATH #16F EVERY MONTH ON THE 25TH- DX: WOUND	:	F	RECEIVED		

on 11/30/16.

physician order to only change the catheter as

needed per the physician's order summary signed

Resident #1's comprehensive care plan initiated on 10/21/16 documented, "Focus: Use of indwelling urinary catheter needed due to sacral

MAK 09 2017

VDH/OLG

PRINTED: 02/28/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NC	. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/S		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		TE SURVEY MPLETED
		495045	B. WING		02	C /15/2017
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES-RICHMOND		2125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	woundIntervention physician order"  On 2/15/17 at 4:00 conducted with RN was asked which F Resident #1 was so whether staff was so catheter every monor to only change the stated the physician dated 11/29/16 to comonth and as need given that order on physician order surindicate he wanted catheter as needed were supposed to f physician's order so catheter as needed were supposed to f physician's order so catheter as needed to change the catheter as neede	p.m., an interview was (registered nurse) #9. RN #9 oley catheter order for upposed to be followed and supposed to change the ath on the 25th and as needed ne catheter as needed. RN #9 in signed the telephone order change the catheter every led to acknowledge he had 11/29/16 but had signed the mary dated 11/30/16 to staff to only change the L. RN #9 stated the nurses follow the order on the ummary and only change the L. When asked why the lad January 2017 TARs ange the catheter every month needed instead of to change eded, RN #9 stated there was a land the TARs should have only lange the catheter as needed.  p.m., ASM (administrative the director of nursing) was above concern. When asked ractice the facility followed, facility nurses followed the cedures. ASM #2 was asked for the red transcription procedure.		RECEIVED MAR 0 9 2017		
	On 2/15/17 at 4:20	p.m., ASM #1 (the				

VDH/OLG

concern.

administrator) was made aware of the above

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES				OMB NO	. 0938-0391	
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495045	B. WING	i		02	C / <b>15/2017</b>	
NAME OF	PROVIDER OR SUPPLIER		:	STREE	T ADDRESS, CITY, STATE, ZIP CODE			
MANOR	CARE HEALTH SERV	ICES-RICHMOND			HILLIARD ROAD MOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 281		age 74 ent titled, "REQUIREMENTS	F	281				

The facility document titled, "REQUIREMENTS AND GUIDELINES FOR CLINICAL RECORD CONTENT" documented, "Transcribing or Noting Orders: Physician orders that are written, telephone or faxed are noted by a licensed nurse. The nurse is responsible for the accuracy of transcription and signs and dates the orders as noted. The licensed nurse, noting the order, transcribes the new medication or treatment onto the patient's Medication Administration Record (MAR) or Treatment Administration Record (TAR). If a medication or treatment is discontinued by the physician, the licensed nurse discontinues the item from the MAR or TAR per center practice..."

No further information was presented prior to exit.

- (1) A Foley catheter is a tube placed in the bladder and used to drain urine. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm
- (2) "A pressure injury (pressure ulcer) is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

RECEIVED

MAR 0 9 2017

VDH/OLG

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495045	B. WING			C 02/15/2017	
	PROVIDER OR SUPPLIER  CARE HEALTH SERV	CES-RICHMOND		STREET ADDRESS, CITY, S 2125 HILLIARD ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD LED TO THE APPROP FICIENCY)	BE COMPLETION	
F 281	orders for nystatin of cream during the mareviewed by a facility the nurse practite #14.  Resident #14 was a	ailed to clarify physician's cream and triamcinolone onthly order recapitulation by nurse on 1/29/17 and signed oner on 1/31/17, for Resident admitted to the facility on	F 2	81 .		·	
	were not limited to: (stroke), chronic pa pressure. Resident (minimum data set) an ARD (assessme	#14's diagnoses included but cerebrovascular disease in syndrome and high blood #14's most recent MDS, a quarterly assessment with nt reference date) of 1/27/17, as being cognitively intact.					
	a physician's order that documented or to: nystatin 100,000 topically applied to twice daily as needed and triamcinolone a applied to the reside daily as needed with physician's order sufailed to documente and triamcinolone a review of Resident a reveal physician's order sufailed to documente and triamcinolone a review of Resident a reveal physician's order sufailed to documente and triamcinolone a review of Resident a reveal physician's order sufailed to documente and triamcinolone a review of Resident a reveal physician's order to the top to the top to the top to the top to the top top top top top top top top top top	#14's clinical record revealed summary signed on 1/11/17 ders including but not limited unit/one gram cream to be he resident's groin/neck/face ed with triamcinolone cream cetonide 0.1% cream to be ent's groin/neck/face twice in nystatin cream. A mmary signed on 1/31/17 d orders for nystatin cream cetonide cream. Further #14's clinical record failed to rders to discontinue the triamcinolone acetonide		RECEIVEL			
	Resident #14's Januadministration recorders including but 100,000 unit/one grant and the second seco	uary 2017 TAR (treatment d) documented physician's not limited to: nystatin am cream (1) to be topically ent's groin/neck/face twice		MAR 0 9 2017 <b>VDH/QLG</b>			

daily as needed with triamcinolone cream and

PRINTED: 02/28/2017

		AND HOMAN OFTANOEO					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COM	E SURVEY IPLETED
		495045	B. WING	<del></del>		1	C 1 <b>5/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	CEC DICUMOND		2125	S HILLIARD ROAD		
MANORO	WAVE LEWFILL SELVI	CEG-MOIMOND		RIC	HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 76	F 2	281			
r 201	triamcinolone aceto applied to the reside daily as needed wit #14's February 201 orders for nystatin of acetonide cream.  Resident #14's componed 2/8/17 document Rash at groin area. The treatment per physion of 2/15/17 at 2:52 conducted with LPN LPN #1 was asked physician order sum contained orders for triamcinolone creams ummary signed 1/1/2 orders when there I discontinue those of the contained orders with the continue those of the contained orders with the cream and scheduled for two with the contained orders with the cream was not available orders for triamcinolone creams ummary signed or triamcinolone creams ummary signed or the contained orders for triamcinolone creams ummary signed or the contained orders for triamcinolone creams ummary signed or the contained orders for triamcinolone creams ummary signed or the contained orders for triamcinolone creams ummary signed or the contained orders for triamcinolone creams unmary signed or the contained orders for triamcinolone creams ummary signed or the contained orders for triamcinolone creams ummary signed or the contained orders for triamcinolone creams ummary signed or the contained orders for triamcinolone creams ummary signed or the contained orders for triamcinolone creams ummary signed or the contained orders for triamcinolone creams ummary signed or the contained orders for triamcinolone creams ummary signed or triamc	onide 0.1% cream (2) to be ent's groin/neck/face twice in nystatin cream. Resident 7 TAR did not document cream or triamcinolone aprehensive care plan revised ted, "Focus: Recurrent YeastInterventions: Administer cian orders"  p.m., an interview was I (licensed practical nurse) #1. to explain why Resident #14's inmary signed on 1/11/17 r nystatin cream and in but the physician's order 31/17 did not contain those had not been an order to reams. LPN #1 stated back in dent #14 had orders for triamcinolone cream weeks then as needed. LPN pht at some point the nystatin vitched to powder because the lable. LPN #1 confirmed the mary signed on 1/11/17 r nystatin cream and in but the physician's order in 1/31/17 did not contain those	manager 1 test on a service.				
	order. LPN #1 also order to discontinue	confirmed she did not see an those creams. LPN #1 ad "dropped off" the latest			ECTIVED AK U9 2017		
	physician order sun	nmary. LPN #1 was asked ocess for physician's orders	-		DHOLG		

during the monthly recapitulation. LPN #1 stated the new physician order summary should be reviewed and compared to the previous physician

Event ID: ODYV11

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR	MEDICARE	& MEDICAID SERVICES			ONB NO	<del>J. 0938-039</del>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY	
		495045	B. WING		02	C 2/ <b>15/2017</b>
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COL	DE	
MANORCARE HE	ALTH SERV	CES-RICHMOND		2125 HILLIARD ROAD RICHMOND, VA 23228		
PREFIX (EAC	CH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	··	HOULD BE	(X5) COMPLETION DATE
			<del></del>	· · · · · · · · · · · · · · · · · · ·		

#### F 281 Continued From page 77

order summary and the telephone orders given between the previous and new physician order summaries. LPN #1 confirmed the discrepancies related to the nystatin cream and triamcinolone cream on the physician order summaries should have been noted during the monthly recapitulation and the physician and pharmacy should have been contacted.

On 2/15/17 at 4:10 p.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above concern. ASM #2 was asked what standard of practice the facility followed and stated the facility nurses followed the facility nursing procedures. ASM #2 was asked to provide a copy of their monthly recapitulation procedure.

On 2/15/17 at 4:20 p.m., ASM #1 (the administrator) was made aware of the above concern.

The facility document titled, "REQUIREMENTS AND GUIDELINES FOR CLINICAL RECORD CONTENT" documented, "Transcribing or Noting Orders: Physician orders that are written, telephone or faxed are noted by a licensed nurse. The nurse is responsible for the accuracy of transcription and signs and dates the orders as noted. The licensed nurse, noting the order, transcribes the new medication or treatment onto the patient's Medication Administration Record (MAR) or Treatment Administration Record (TAR). If a medication or treatment is discontinued by the physician, the licensed nurse discontinues the item from the MAR or TAR per center practice...PHYSICIAN ORDER RECAP PROCESS: The Physician Order Recap process is completed monthly for both paper and

F 281

RECEIVED

MAR 0 9 2017

ADH/OFC

PRINTED: 02/28/2017 FORM APPROVED OMB NO, 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO, 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
-		495045	B. WING		C 02/15/2017	
NAME OF	PROVIDER OR SUPPLIER		<u>''                                   </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES DICHMOND		2125 HILLIARD ROAD		
MANURU	JAKE NEALIN SEKVI	ICES-RICHMOND		RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
F 281	Continued From pa	nge 78	F 2	81		
	•	nters. Paper physician order				
		al Record professional collects				
		hysician Order Recap Sheets	-			
		an signatures per center	-			
		deral/state regulatory sician Signed Physician Order				
		e filed in the patient's medical				
	record"	•				
	No further informat	ion was presented prior to exit.				
	(1) Nystatin cream	is used to treat fungal				
	infections. This infe	ormation was obtained from				
	the website:					
	nttps://mealineplus. tml	.gov/druginfo/meds/a682758.h	:			
	(2) Triamcinolone is	s used to treat itching, redness	1			
	and inflammation of	f the skin. This information				
	was obtained from		:			
	https://mediineplus. ml	.gov/druginfo/meds/a601124.ht				
	3 The facility staff t	failed to document a verbal				
		d transcribe the order onto the				
		dministration record) for				
	Resident #12 was a	admitted to the facility on				
		ses that included but were not				
		cancer, chronic obstructive	:	RECENTER		

Facility ID: VA0241

MAR 0 9 2017

a normal heart rhythm (1)).

pulmonary disease (COPD), cataracts, and has a

pacemaker (an electrical device used to maintain

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/24/16, coded

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION  NING	(X3) DATE SURVEY COMPLETED	
		495045	B. WING		02	C /15/2017
	PROVIDER OR SUPPLIER  CARE HEALTH SERV	CES-RICHMOND		STREET ADDRESS, CITY, STATE, ZIP CO 2125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 281	daily decisions. The requiring supervision activities of daily live. The physician order by the physician order by the physician order by the physician order documented, "MAP fever or mild to more (milligrams) tablet; mouth every 4 hour (greater than) 100.5. Review of the Februadministration reconstruction of the februadministration reconstruction of the MAR document of nurse) Tylenol 65 2/11/17 at 4:50 p.m. and 2/11/17 at 4:50 p.m. mg c/o (complaint of the nurse nurse's notes for 2/2 An interview was constaff member (ASM nursing; on 2/15/17 asked to review the Tylenol. When asked Tylenol, ASM #3 statemperature greater nurse can give the complain of a head-	ing cognitively intact to make the resident was coded as an to independent for all of his ling.  In stated 6/22/15 and renewed 12/26/16 and 1/22/17, AP (Tylenol)(used to treat derate pain (2)) 325 MG 2 tabs (tablets) (650 MG) by as a needed for temperature > 6 (100.5 degrees Fahrenheit)."  Luary 2017 MAR (medication and) documented, "MAPAP ablet; 2 tabs (650 MG) by as a needed for temperature > 6 (100.5 degrees Fahrenheit)."  Luary 2017 MAR (medication and) documented, "MAPAP ablet; 2 tabs (650 MG) by as a needed for temperature > 6 (100.5 degrees) and the resident to see of Tylenol on 2/9/17 at 9:25 at:50 p.m. The reverse side of ed, "2/9/17 9:25 p.m. (initials of my headache - effective."  Let's notes did not reveal any		RECEIVED MAR 0 9 2017 VDH/OLG		

contact the physician."

PRINTED: 02/28/2017

		AND HUMAN SERVICES			FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	<del></del>		<u> </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495045	B. WING	annihan anaron a con area a con a co	C 02/15/2017
NAME OF P	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
*****	ADE HEALTH CENT	CEC DICUMOND	İ	2125 HILLIARD ROAD	
MANORU	ARE HEALTH SERVI	CES-KICHMOND		RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		DBE COMPLETION
F 281	Continued From pa	ge 80	F2	281	
	practical nurse) #10 both doses of Tylen 2:27 p.m. When as take if a resident re stated, "Well, first y want it. You would r it for anything other prescribed for. I wo of the resident's coif I could give him the that order, then order and write a ne #10 stated, "I try to building I'm working weeks ago at the far	onducted with LPN (licensed of the nurse who administered of in February, on 2/15/17 at ked what steps she would quested Tylenol, LPN #10 ou have to find out why they need a physician order to give than what the orders says it's uld call the doctor and tell him implaint of a headache and ask ne Tylenol. If the doctor gave I'd have to write a verbal lew order on the MAR." LPN follow the policies of the pin. I just started about three cility. I keep notes of my ated she would check her with this surveyor.	:		
	surveyor and stated called the doctor an Tylenol to give the r Tylenol for headach needed); not to exchours." When asked documented the ph "Yes, I should have have transcribed the headache onto the Ma'am, I should have don't see it there."	p.m. LPN #10 called this i, "I found my notes. I had id got a new order for the esident (Resident #12) two e every six hours PRN (as eed three to four grams in 24 d if she should have ysician order, LPN #10 stated, "When asked if she should e new order for Tylenol for MAR, LPN #10 stated, "Yes, ye but I guess I didn't if you		RECEIVED  MAR 0 9 2017	
	for Clinical Record	Requirements and Guidelines Content" documented in part, hone order form is completed		VDH/OLG	

for each telephone or verbal order received...The qualified professional writes the order and reads it

PRINTED: 02/28/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OM	B NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		· [6	(X3) DATE SURVEY COMPLETED	
		495045	B. WING			C <b>02/15/2017</b>	
NAME OF	PROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				2125 HILLIARD ROAD			
MANOR	CARE HEALTH SERVI	ICES-RICHMOND		RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD E ED TO THE APPROPRI ICIENCY)		
F 281	practitioner verbally order. This verificat verbal telephone or	he initiation practitioner. The confirms or corrects the cion process applies to each securely messaged order.	F 2	81			
	attending physician defined by state reg	re signed and dated by the within the period of time gulations."					
	Patricia A. Potter at Inc; Page 336. "Th provider should writ responsible for tran orders. If a verbal an emergency), har	of Nursing" 7th edition, 2009: and Anne Griffin Perry: Mosby, we physician or health care the all orders. The nurse is ascribing correctly written order is necessary (e.g. during we it written and signed by the care provider as soon as a within 24 hours."					
	The administrator v concern on 2/15/17	vas made aware of the above ' at 4:35 p.m.		RECEIVE			
	(1) Barron's Diction Non-Medical Read Chapman; page 42	eary of Medical Terms for the er 5th edition, Rothenberg and	* §	MAR 0 9 2017			
	(2) This information following website:	n was obtained from the m.nih.gov/pubmedhealth/PMH	:	VDH/OLG	) :		
F 282 SS=D		RVICES BY QUALIFIED ARE PLAN	F	282 F-28	32	3/31/17	
	(b)(3) Comprehens The services provid as outlined by the c must-	sive Care Plans ded or arranged by the facility, comprehensive care plan,		It is the intended facility to ensur- provided or arr provided by qual accordance with	e that services anged must be ified persons in		
	(ii) Re provided by	qualified persons in		accoraance wiin	P		

written plan of care.

Facility ID: VA0241

(ii) Be provided by qualified persons in

accordance with each resident's written plan of

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 02/28/2017 FORM APPROVED DMB NO. 0938-0391	
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495045	B. WING		C 02/15/2017	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVI	ICES-RICHMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	ON (X5) D BE COMPLETION PRIATE DATE		
	by: Based on staff inte and clinical record the facility staff faile	nge 82  NT is not met as evidenced erview, facility document review review, it was determined that ed to follow the care plan for in the survey sample,	F 2	Criteria 1  Resident#11 was assessed for new of continuous pulse oximetry saturations check and it was clarified by MD that he does not need it at this time and care plan updated.		
		to follow the care plan to check saturations (1) each shift for	i	<u>Criteria 2</u> All residents have a potential to	be	

The findings include:

Resident #11.

Resident #11 was admitted to the facility on 10/21/15 and was readmitted on 11/3/16 with diagnoses that included but were not limited to: stroke, heart disease, irregular heartbeat, high blood pressure and dementia.

The most recent MDS (Minimum Data Set), a 14 day assessment, with an ARD (Assessment Reference Date) of 11/16/16 coded the resident as having a nine out of 15 on the BIMS (Brief Interview for Mental Status) indicating the resident was moderately cognitively impaired. The resident was coded as needing assistance from staff for activities of daily living except for eating which the resident could do once the meal tray was prepared. The resident was coded as receiving oxygen.

Review of the physician's order dated 2/22/16 documented, "O2 prn (as needed)."

Review of Resident #11's care plan initiated on 10/2/15 and revised on 12/2/15 documented,

All residents have a potential to be affected.

#### Criteria 3

The interdisciplinary team will be re-educated to ensure that care plans are followed.

#### Criteria 4

DON or designee will audit 5 Residents care plan to ensure that residents care plans are followed dailyx5 days, three times

weeklyx3weeks and monthlyx2months

#### Criteria 5

The facility's alleged date of compliance is 3/31/2017.

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

Event ID: ODYV11

RECEIVED

If continuation sheet Page 83 of 134

MAR 09 20!?

**VDH/QLG** 

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURV COMPLETE			
						С			
		495045	B. WING			02/15/20	17		
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE				
MANORO	CARE HEALTH SERVI	CES-RICHMOND			25 HILLIARD ROAD CHMOND, VA 23228				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMP	X5) LETION ATE		
F 282	MI (myocardial infarattack)Interventice ordered, monitor of every shift."  Review of the TARs records) for Februar 2016 did not evident oxygen saturations.  Review of the nurse documentation of a done every shift.  An interview was coa.m., with RN (registral manager. When as RN #3 stated, "Every When asked if nurse care plan, RN #3 stated aware of the An interview was cop.m. with ASM (admitted director of nursi of Resident #11) had oxygen when he (Rebruary 2016 until November. It wasn' back." When asked oxygen and oxygen documented on the November 2016, Asterior asked oxygen and oxygen documented on the November 2016, Asterior asked oxygen and oxygen documented on the November 2016, Asterior asked oxygen and oxygen documented on the November 2016, Asterior asked oxygen and oxygen and oxygen and oxygen and oxygen documented on the November 2016, Asterior asked oxygen and oxyg	ease related to Hx (history) of rction, heart ons Administer oxygen as 2 sats (oxygen saturations)  s (treatment administration or 2016 through November ace documentation of the		282	RECEIVED  MAR 0 9 2017				
		When asked if staff were			error was EU1.				

expected to follow the care plan, ASM #2 stated they were. ASM #2 was made aware of the

VDH/QLC

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495045	B. WING	<del></del>	C
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	·		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228	02/15/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 282	Continued From pa	ge 84	F 28	32	
	surveyor nurse's no	p.m. ASM #2 gave this tes dated from 3/29/16 to a five pulse oximetry's			
	documented, "CAR care plan is a commembers of the interior in how to meet each also identifies the ty the patient should reprocess: Implement developed, the staff interventions identified may include, but is a	y's policy titled, ARY CARE PLANNING" E PLANNING: The patient' d nunication tool that guides erdisciplinary healthcare tram in individual patient's needs. It is and methods of care that eccive. CARE PLANNING entation Once the care plan is is must implement the fied in the care plan. These not limited to: administering lications, performing			
		on was provided prior to exit.		RECEIVED	
	oximetry is common	- Oxygen saturation by pulse ly used for monitoring critical nation was obtained from:		MAR 0 9 2017	
	https://www.ncbi.nlm %20Esp%20Cardio	n.nih.gov/pubmed?term=Rev %5BJour%5D%20AND%206 20AND%20879%5Bpage%5		VDH/OLG	
	483.25(b)(2)(f)(g)(5) FOR SPECIAL NEE	(h)(i)(j) TREATMENT/CARE DS	F 32	8 F-328	3/31/17
		ensure that residents receive d care to maintain mobility n, the facility must:		It is the intended practice of this facility to ensure that residents receive proper treatment and care for special services including but	
	(i) Provide foot care	and treatment, in accordance		not limited to respiratory care and	t t

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NO	<u>). 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495045	B. WING	i		02	C 2/15/2017
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	· · · · · · · · · · · · · · · · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
******	34DF 11F41TH 05D1	oro mouseoup		21	125 HILLIARD ROAD		
MANOR	CARE HEALTH SERV	CES-RICHMOND		R	ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 222	Continued From no	9E	;	200	that care be consistent with		3/31/17
F 320	Continued From pa	<b>▼</b>		328		2	,
		andards of practice, including itions from the resident's	į		professional standards of practice the comprehensive care plan, and		
	medical condition(s				the resident's goals and	•	
		• •			preferences.		
		sist the resident in making			pregerences.		
		a qualified person, and			Criteria 1		
	arranging for transpappointments			Upon notification from surveyor			
	арронински			`` <u> </u>	of resident #22 nebulizer mask		
	(f) Colostomy, uret	erostomy, or ileostomy care.	,		being out bag, nebulizer mask wa	S	
	The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with				replaced and stored appropriately		
					the empty oxygen cylinder was		
	professional standa				removed immediately and stored		
		son-centered care plan, and			properly in the designated oxyger	l	
	the resident's goals				storage rack.		
	(g)(5) A resident wh	io is fed by enteral means			Criteria3		
		riate treatment and services	•		The interdisciplinary team		
		ications of enteral feeding			including nursing staff, rehab and		
		ited to aspiration pneumonia, dehydration, metabolic			ancillary staff will be re-educated		
		nasal-pharyngeal ulcers.			on the facility procedures of		
		taoa. pr.a. jrigoa. a.ou.o.			oxygen storage		
	, ,	s. Parenteral fluids must be			The nursing staff will be		-
		stent with professional			reeducated on nebulizer equipme	nt	
		e and in accordance with			storage to ensure safety and prop	er	
	physician orders, the nerson-centered ca				sanitary use.		
	person-centered care plan, and the resident's goals and preferences.						
		including tracheostomy care			RECEIVED		
		ning. The facility must ensure			The Man I When he		
	that a resident who needs respiratory care, including tracheostomy care and tracheal				MAR 09 2017		
	suctioning, is provided such care, consistent was professional standards of practice, the			VDH/OLG			

comprehensive person-centered care plan, the

		AND HUMAN SERVICES				FORM	): 02/28/201/ MAPPROVED ) 0038_0301
STATEMENT	CONTROL MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495045	B. WING	<u>-</u>		02	C 2/15/2017
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-RICHMOND			25 HILLIARD ROAD ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 328	(j) Prostheses. The resident who has a and assistance, constandards of practic person-centered cand preferences, to prosthetic device.	ge 86 d preferences, and 483.65 of e facility must ensure that a prosthesis is provided care ensistent with professional ce, the comprehensive are plan, the residents' goals of wear and be able to use the NT is not met as evidenced	F :	328	Criteria 4  DON or designee will audit resident rooms and oxygen designated area in facility to ensure proper storage of oxygen and proper sanitation of nebulize masks dailyx5 days, three times weeklyx3weeks and monthlyx2months		3/31/17

Based on observation, staff interview, clinical

record review and facility document review it was determined that the facility staff failed to store oxygen equipment in a sanitary manner for one of 29 residents in the survey sample, Resident # 22 and failed to store oxygen in a safe manner in the

facility oxygen storage room.

by:

- 1. The facility staff failed store to a nebulizer mask in a sanitary manner for Resident # 22.
- 2. Facility staff failed to properly store an empty two liter oxygen cylinder of oxygen in the oxygen cylinder storage rack in the facility's oxygen storage room. The empty 2 liter oxygen cylinder was observed unsecured, lying on its side on top of the oxygen cylinder storage rack.

The findings include:

1. The facility staff failed to store a nebulizer mask in a sanitary manner for Resident # 22.

Resident # 22 was admitted to the facility on 07/17/09 and readmitted on 06/30/16 with diagnoses that included but were not limited to:

#### Criteria 5

The facility's alleged date of compliance is 3/31/2017.

RECEIVED

MAR 0 9 2017

VDH/QLG

PRINTED: 02/28/2017

		AND HOMAN SERVICES			_		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	·			<u>MR NC</u>	). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		LE CONSTRUCTION		TE SURVEY MPLETED
		495045	B. WING	3		03	C 2/15/2017
NAME OF F	PROVIDER OR SUPPLIER		L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	110/2017
MANODO	CARE HEALTH SERVI	CES-RICHMOND		1	2125 HILLIARD ROAD		
MANORO	SARE HEALIN SERVI	OLO-MONIMOND		<u> </u>	RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 328	Continued From pa	ae 87	F	328	' }		
. 523	•	us (1), history of a stab wound,		<b>-</b>	-		
		rtension (3), pneumonia (4)					
		perplasia (5), chronic kidney					
	<b>,</b> ,	onic obstructive pulmonary					-
	disease [COPD] (7)	)-					
	Resident # 9's mos	t recent comprehensive MDS					
	(minimum data set)	a significant change					
		n assessment reference date					
	,	coded the resident as scoring					
		nterview for mental status of 0 - 15, five being severely	:				
		on for daily decision making.			*		
	impanda or oogimie	g.			•		
		n's order sheet) dated					
	02/01/17- 02/28/17		1				
		4/17 Routine. IPRAT-ALBUT buterol (8)] 0.5-3 mg					
		milliliter) via (by) nebulizer					
		OX (diagnosis) COPD"					
	·						
		p.m. an observation of					
		m revealed a nebulizer (9) sident # 22's bedside table.	į				
		nebulizer revealed the tubing					
	=	ebulizer was connected to a					
	breathing mask. TI	he mask was placed on the					
		d and exposed to the					
	environment.						
	On 02/15/17 at 1:26	p.m. an observation of					
		m revealed the nebulizer					
		sident # 22's bedside table.			RECEIVED		
		nebulizer revealed the tubing			The same of the sa		
	running from the ne	bulizer was connected to a			MAD D D DOG		

MAR 0 9 2017

VDH/OLG

environment.

breathing mask. The mask was placed on the nebulizer uncovered and exposed to the

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENIE	RS FUR MEDICARE	& MEDICAID SERVICES				<u> MR MO</u>	<u>. 0938-0391</u>	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495045	B. WING	·		I .	C /15/2017	
NAME OF	PROVIDER OR SUPPLIER		•	STRI	ET ADDRESS, CITY, STATE, ZIP CODE			
MANODA	CARE HEALTH SERV	ICES DICUMOND		2125	HILLIARD ROAD			
MANOR	JAKE REALIN SERV	CES-RICHINOND		RIC	HMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  .	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 328	Continued From pa	ge 88	' F3	328				
	•	roximately 2:09 p.m. an					***************************************	
	interview was cond	ucted with LPN (licensed			•		T T T T T T T T T T T T T T T T T T T	
		. LPN #2 was asked to						
		lure for storing a nebulizer in use. LPN # 2 stated, "It						
		a plastic bag if it's not in use."						
		p.m. an observation of	:					
	and the second s	m was conducted with LPN # ne room, LPN # 2 was asked	1					
		lizer positioned on top of	1					
		Iside table. After observing	-					
		ılizer mask, LPN # 2 stated,						
	"That (the nebulizer I'm going to replace	mask) should be in a bag.					'	
	ini going to replace	uic indsk.						
		"Respiratory: Nebulizer Mist						
		ed, "Procedure: 19. Store					ļ	
	separate, labeled pl	ece, mouthpiece or mask in						
	Separate, labeled pi	asic bag.					İ	
		roximately 2:00 p.m. ASM						
	(administrative staff							
		ASM # 2, the director of aware of the findings.						
	narsing, were made	aware or the infulligs.						
	No further informati	on was provided prior to exit.					İ	
	References:							
		f Nursing" 7th edition, 2009: d Anne Griffin Perry: Mosby,			RECEIVED			
		x 34-2 Sites for and Causes			MAR 0 9 2017			
	of Health Care-Asso	ociated Infections under						
	therapy equipment.	Contaminated respiratory			<b>VDH/QLG</b>		-	

(1) A changed level of awareness or mental state

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION ING	(X3) DATE SU COMPLET	
		405045	B. WING		С	
NAME OF I	SOURCES OF GUIDNIES	495045	D. WING	OTHER ADDOCAG ANY STATE TO CARE	02/15/2	2017
	PROVIDER OR SUPPLIER  CARE HEALTH SERVI	CES-RICHMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROPRIED TO TH	BE CO	(X5) MPLETION DATE
F 328	Continued From pa	ge 89	· F3	<b>28</b>	:	
	that falls short of ur Examples AMS Cor stupor (which, if of a medical emergency obtained from the w	nconsciousness. Infusion, disorientation, or sudden onset, constitutes a representation was rebsite: Inary.thefreedictionary.com/alt			:	
	virus that causes Al immunodeficiency s becomes infected weakens the immun system weakens, the life-threatening infer happens, the illness person has the virus life. This information website:	odeficiency virus (HIV) is the IDS (acquired syndrome). When a person with HIV, the virus attacks and he system. As the immune he person is at risk of getting ctions and cancers. When that is is called AIDS. Once a s, it stays inside the body for in was obtained from the gov/ency/article/000594.htm.				
	obtained from the w	sure. This information was rebsite: .gov/medlineplus/highbloodpr	:	·		
	germs, such as bac cause pneumonia. Y by inhaling a liquid of was obtained from t	ne or both of the lungs. Many teria, viruses, and fungi, can fou can also get pneumonia or chemical. This information he website: gov/pneumonia.html,		RECEIVED		
	obtained from the w			MAR 0 9 2017		
	https://www.nlm.nih.statebph.html.	.gov/medlineplus/enlargedpro		<b>VDH/OLG</b>		

(6) Kidneys are damaged and can't filter blood as

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	<u> </u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR		(X3) DATE SURVEY COMPLETED		
		495045	B. WING				C 2/15/2017	
	ROVIDER OR SUPPLIER	CES-RICHMOND		2125 HILLI	DRESS, CITY, STATE, ZIP CODE ARD ROAD ID, VA 23228	<u>:</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х <u>(Е</u>	PROVIDER'S PLAN OF CORREC ACH CORRECTIVE ACTION SHO DSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 328	the website: https://medlineplus.l.  (7) Disease that macan lead to shortne was obtained from https://www.nlm.nih  (8) The combination is used to prevent with the combination is used to prevent with the controlled by a sing and the controlled by a sing Albuterol and used by people who controlled by a sing Albuterol and ipratronium combinations called ipratropium combinations called ipratropium combinations that it is not the website: https://medlineplus.tml.  (9) Because you have the controlled by a sing Albuterol and ipratropium combinations called ipratropium combinations called ipratropium combinations that it is not the website: https://medlineplus.tml.	gov/chronickidneydisease.htm  akes it difficult to breath that ss of breath. This information the website: a.gov/medlineplus/copd.html.  In of albuterol and ipratropium wheezing, difficulty breathing, dicoughing in people with pulmonary disease (COPD; a hat affect the lungs and pronic bronchitis (swelling of at lead to the lungs) and ge to the air sacs in the dipratropium combination is ose symptoms have not been le inhaled medication.  Topium are in a class of bronchodilators. Albuterol and ation works by relaxing and sages to the lungs to make this information was obtained gov/druginfo/meds/a601063.h  Topium are in a class of bronchodilators are laxing and sages to the lungs to make this information was obtained gov/druginfo/meds/a601063.h  Topium are in a class of bronchodilators and ation works by relaxing and sages to the lungs to make this information was obtained gov/druginfo/meds/a601063.h  Topium are in a class of bronchodilators are laxing and sages to the lungs to make this information was obtained gov/druginfo/meds/a601063.h  Topium are in a class of bronchodilators are laxing and sages to the lungs to make this information was obtained gov/druginfo/meds/a601063.h  Topium are in a class of bronchodilators are laxing and sages to the lungs to make this information was obtained gov/druginfo/meds/a601063.h			CEIVED R 0 9 2017			
		a connected mouthpiece. your lungs as you take slow,		VD	HOLC			

Medicine goes into your lungs as you take slow, deep breaths for 10 to 15 minutes. It is easy and pleasant to breathe the medicine into your lungs

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495045	B. WING _		C <b>02/15/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228	Vac i van vii
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 328	this way. This infor website: https://medlineplus 00006.htm.	rmation was obtained from the .gov/ency/patientinstructions/0		28	
	two liter oxygen cyl cylinder storage rac storage room. The	ed to properly store an empty inder of oxygen in the oxygen ck in the facility's oxygen empty 2 liter oxygen cylinder ecured, lying on its side on top der storage rack.	-		
	facility's oxygen sto Room (the activity of OSM (other staff of Operations. Upon of oxygen storage roo cylinder was observation side on top of the of Further observation cylinder with OSM #	5 p.m. an observation of the brage room next to the "Lee room) was conducted with ember) # 6, Director of Plant opening the door to the or a two liter portable oxygen yed unsecured, lying on its oxygen cylinder storage rack. In of the portable oxygen # 6 confirmed that the cylinder # 6 stated, "They should be		RECEIVED	
	(administrative staff	roximately 3:15 p.m. ASM f member) # 1 the made aware of the findings.		MAR 0 9 2017 VDH/OLG	
F 329 SS=D		ion was provided prior to exit. EGIMEN IS FREE FROM RUGS	F 32	29 F-329	3/31/17
	drug regimen must	rugs-General. Each resident's be free from unnecessary sary drug is any drug when		It is the intended practice of th facility to ensure each resident drug regimen is free from unnecessary drugs.	

PRINTED: 02/28/2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES			Agent Maries	FORM APPROVE
CENTERS FOR MEDICARE	& MEDICAID SERVICES		O	<u>MB NO. 0938-039</u>
<del></del>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				С
	495045	B. WING	in the second se	02/15/2017
NAME OF PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
MANORCARE HEALTH SERV	ICES-RICHMOND	1	25 HILLIARD ROAD CHMOND, VA 23228	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
		· · · · · · · · · · · · · · · · · · ·		3/31/17

#### F 329 Continued From page 92

- (1) In excessive dose (including duplicate drug therapy); or
- (2) For excessive duration; or
- (3) Without adequate monitoring; or
- (4) Without adequate indications for its use; or
- (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced

Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure the drug regimen for one of 29 residents in the survey sample, (Resident #12) was free of unnecessary medications.

The facility staff administered Tylenol to Resident #12 without adequate indications for administration of the medication on two occasions in December 2016.

The findings include:

Resident #12 was admitted to the facility on 6/21/15 with diagnoses that included but were not limited to: bladder cancer, chronic obstructive pulmonary disease (COPD), cataracts, and has a pacemaker (an electrical device used to maintain a normal heart rhythm (1)).

#### F 329

Criteria 1

MD was notified that resident received Tylenol for headache instead of fever as initially indicated.MD gave new orders for Tylenol for headache at this time.

#### Criteria 2

Any and all residents have the potential to be affected.

#### Criteria 3

Licensed nurses will be reeducated to ensure understanding of instruction and indication on MD orders

#### Criteria 4

DON or designee will audit MAR daily x5 days, three times weekly x3 weeks and monthly x2 months.

#### Criteria 5

The facility's alleged date of compliance is 3/31/2017.

#### RECEIVED

MAR 0.9 2017

VDH/OLC

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					O	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495045	B. WING			C 02/15/2017
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
MANORO	CARE HEALTH SERVI	ICES-BICHMOND		2125	5 HILLIARD ROAD	
WMITOIN	WARE HEARIN OFFICE	(CCO-INICIAL)		RIC	HMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 329	Continued From pa	age 93	F:	329		
	•	DS (minimum data set)				
	assessment, a quai	rterly assessment, with an				
		nce date of 12/24/16, coded				
		ng cognitively intact to make election in a resident was coded as	-			
		on or was independent for all of				
	his activities of daily					
		ers dated 6/22/15 and renewed 12/26/16 and 1/22/17,				
		PAP (Tylenol)(used to treat	:			
		derate pain) (2) 325 MG				
	(milligrams) tablet; 2	2 tabs (tablets) (650 MG) by				
		rs as needed for temperature >				
	(greater than) 100.5	5 (100.5 degrees Fahrenheit)."				
	administration recor	6 MAR (medication rd) documented, "MAPAP				
		ablet; 2 tabs (650 MG) by				
	mouth every 4 hours (greater than) 100.5	rs as needed for temperature >				
		o. The Tylenol was ving been administered on				
		m. and 12/21/16 at 6:00 p.m.				
		f the MAR was blank.				
		Logs" in the computer system ny temperatures taken on 6.				
	Review of the nurse	e's notes did not reveal any				
		12/19/16 or 12/21/16 regarding				
		of Tylenol to Resident #12.			RECEIVED	
		onducted with RN (Registered			MAR 0 9 2017	
		manager; on 2/15/17 at 9:45			• • •	
		ked to review the above en asked when a nurse could			ADH/OFC	
		nol, RN #3 stated, "They can			All the second s	

only give it for a fever greater than 100.5." The

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO	OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		TE SURVEY MPLETED	
		495045	B. WING	i		02	C 2/15/2017	
	PROVIDER OR SUPPLIER			2125	EET ADDRESS, CITY, STATE, ZIP CODE 5 HILLIARD ROAD HMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 329	MAR for December #3. When asked is was given, RN #3 been given without will look in to this at An interview was a staff member (ASI nursing; on 2/15/1 asked to review the Tylenol. When ask Tylenol, ASM #3 stemperature great nurse can give the reason than what physicians order, where the terms is the type of the type of the type of the type of the type of the type of the type of type of the type of type	er 2016 was reviewed by RN If he could say why the Tylenol stated, "It should not have t clarification from the doctor. I and get back with you."  conducted with administrative M) #3, the assistant director of 7 at 9:58 a.m. ASM #3 was e above physician order for ted when a nurse can give the tated, "If the resident had a er than 100.5." When asked if a er tesident Tylenol for any other was documented in the ASM #3 stated, "No, they would e physician." ASM #3 was e nurse who had given the		329				
	surveyor that the r no longer employed. The facility policy, Medication Pass" "Procedure: Read MAR; patient name route and interval from cart, compare accuracy. If medi- medication is unfa- questioned: read of compare original paccuracy, remove compare MAR with	22 a.m. ASM #3 informed this nurse who gave the Tylenol was ed at the facility.  "Medication Administration: documented in part, transcribed physician order on e, medication name, dosage, ordered: remove medication e MAR with medication label for cation is new for patient, or if miliar or physician order is original physician order, ohysician order with MAR for d medication label for accuracy, s, contact physician, if needed."			RECEIVED  MAR 0 9 2017  VDH/OLG			

According to "Fundamentals of Nursing", Seventh

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

OE VE	TO 1 OIL MILDIONINE	. A MILDIO/ND OLIVIOLO			<u> </u>	WID 140	. 0000 000 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495045	B. WING			1	C
		493043	D. WING	,	· · · · · · · · · · · · · · · · · · ·	02/	15/2017
	PROVIDER OR SUPPLIER  CARE HEALTH SERVI	CES-RICHMOND		21	REET ADDRESS, CITY, STATE, ZIP CODE 25 HILLIARD ROAD ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 329	Edition, 2009: by Pe "Medication Adminisread: "Professional American Nurses A and Standards of N to the activity of me prevent medication medication adminis	ge 95 erry and Potter Chapter 35 stration" Chapter 35, pg. 707 standards, such as the ssociation's Nursing: Scope lursing Practice (2004) apply dication administration. To errors, follow the six rights tration consistently every time lications. Many medication	F:	329			
	errors can be linked inconsistency in adl medication adminis medication adminis. The right medication right client, 4. The right document of the right doc	d, in some way, to an hering to the six rights of tration. The six rights of tration include the following: 1. n, 2. The right dose, 3. The ight route, 5. The right time, cumentation." Under the toute (on pg. 708) "When ions, precautions are a the nurse gives the					
	nursing, and ASM #	ASM #2, the director of 4, the corporate quality ere made aware of the above at 2:00 p.m.					
	483.60(c)(1)-(7) ME	on was provided prior to exit. NUS MEET RES DVANCE/FOLLOWED	F:	363	F-363		3/31/17
	(c) Menus and nutri	tional adequacy.			It is the intended practice of this	ı	
	Menus must-				facility to meet the nutritional needs of residents in accordance with the recommended dietary	!	
		itional needs of residents in tablished national guidelines.;			allowances of the Food and Nutrition Board of the National		
	(c)(2) Be prepared i	n advance;					

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

Event ID: ODYV1RECEIVED 41

If continuation sheet Page 96 of 134

MAR 0 9 201?

PRINTED: 02/28/2017 **FORM APPROVED** 

CENTERS FOR MEDICARE	: & MEDICAID SERVICES			MB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
	495045	B. WING		C 02/15/2017	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORCARE HEALTH SERV	ICES-RICHMOND		2125 HILLIARD ROAD RICHMOND, VA 23228		
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
			:	7/21/17	

3/31/1

#### F 363 Continued From page 96

(c)(3) Be followed;

- (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;
- (c)(5) Be updated periodically;
- (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and
- (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.

This REQUIREMENT is not met as evidenced

Based on observation, staff interview and facility document review, it was determined that the facility staff failed to ensure protein portions served were sufficient to meet the nutritional needs of residents on a regular diet.

The facility staff failed to serve the three ounce serving of barbeque beef and ham per the facility's planned menu for residents on regular diet at the 2/15/17 lunch meal.

#### The findings include:

An observation of tray preparation was made on 2/15/17 at 11:40 a.m. The server was observed placing the beef slices on the plates. The beef slices were of similar size and the server would place one slice on each plate except when the resident was to get double portions in which case F 363

Research Council, National Academy of Sciences.

#### Criteria 1

Upon notification from surveyor CDM re-educated server of protocol related to portion control standards to ensure nutritional adequacy.

#### Criteria 2

Any and all residents have the potential to be affected.

#### Criteria 3

All dietary staff to be re-educated regarding nutritional adequacy including but not limited to policies and procedures related to serving/portion control equipment.

#### Criteria 4

Administrator or designee will audit tray line setup/serving process using tray line audit tool daily x3 for 2 weeks, then once daily for following 2 weeks, 2x weekly on an on-going basis.

#### Criteria 5

The facility's alleged date of compliance is 3/31/2017.

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

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 97 of 134

RECEIVED

MAR 0.9 2017

VDH/OLG

PRINTED: 02/28/2017 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					0. 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495045	B. WING		The state of the s	02	C 2/15/2017		
NAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE				
MANOR	CARE HEALTH SERV	CES-RICHMOND			HILLIARD ROAD HMOND, VA 23228				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG	<b>,</b>	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 363	A new tray of beef was table and the slices thinly cut. The serve to four slices of the of the servings to be was observed placiplates with a half a slices were different On 2/15/17 at 12:10 service a request was member) #15, the observed the slices was a slice was a sl	wo slices of beef on the plate. was brought to the serving were observed to be very er was observed placing one beef on the plates with most e one slice of beef. The server ng a half a slice of ham on the slice of pineapple. The ham t sizes.  O p.m. at the end of the tray as made to OSM (other staff lirector of dining services to		63					
	weighed 1.75 ounce 2 ounces. When as the residents were "Four ounces." Whe	the ham. The beef slices es and the ham slice weighed ked how much beef or ham to receive, OSM #15 stated, en asked if the residents had t amount, OSM #15 stated,							
	p.m. with OSM #14 food. When asked were to be served, ounces." When ask sliced meat to serve beef comes in a log same." When asked OSM #14 stated, "No gave some resident slices of beef, OSM of beef for the resid with the thinner slice give them the portion.	inducted on 2/15/17 at 1:35, the cook who served the now much meat the residents OSM #14 stated, "Four ed how she knew how much et, OSM #14 stated, "Pork and shape. I cut each portion the diff the portions were weighed, lo." When asked why she is one slice of beef to four #14 stated, "I gave four slices ents getting double portions. es (of beef) I gave more to on size. I kinda eye-balled it."			RECEIVED MAR 0 9 2017				
		was important that residents			VDH/OLC				

received the correct amount of meat, OSM #14 stated, "its protein. It's for their nutrition."

PRINTED: 02/28/2017 **FORM APPROVED** 

STATEMENT OF DEFICIENCIES AND PLANOF CORRECTION  AND PLANOF CORRECTION  A95045  MANORCARE HEALTH SERVICES-RICHMOND  MANORCARE HEALTH SERVI	_ CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
MANDE OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-RICHMOND    O(A) ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   PREERY (EACH DEFICIENCY MUST BE PRECEDED BY FILL)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION)   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION   TAG   REGULATORY OR INFORMATION   TAG   REGULATORY OR IS CIDENTIFYNO INFORMATION   TAG   TA								
MANORCARE HEALTH SERVICES-RICHMOND  (X24) D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL RESULATIONY OR LIST DEPATIFYING INFORMATION)  F 363 Continued From page 98 Review of the facility's menu documented, "BARBEQUE BEEF 302 (counces) REG (regular diet) 40Z. HAM W/ (with) PINEAPPLE 30Z. REG 60Z.  On 2/15/17 at 2:03 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing were made aware of the findings.  An interview was conducted on 2/15/17 at 2:30 p.m. with OSM #11 and #16, the dietitians. OSM #11 and #16 were asked to review the menu. When asked what portion size of beef and ham the residents were to receive, OSM #11 stated, "Whatever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what their rate of weight loss would occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "Its not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four-ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces on the menu means the resident should receive three ounces of ham and the pineapple silce (which would equal six ounces."  No further information was provided prior to exit.  F 364  A3/31/17  F 365			495045	B. WING	;		t .	-
CALL   DEADLY   DEA	NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
Summary statement of periciencies   Prefer   RICHMOND, WA 23228	****	04mm	IOCO DIOLIMOND		:	2125 HILLIARD ROAD		
FREEIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAGE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DATE DEFICIENCY)  F 363 Continued From page 98 Review of the facility's menu documented, "BARBEOULE BEEF 30Z (ounces) REG (regular diet) 40Z. HAM W/ (with) PINEAPPLE 30Z. REG (60Z.  On 2/15/17 at 2:03 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing were made aware of the findings.  An interview was conducted on 2/15/17 at 2:30 p.m. with OSM #11 and #16, the dietitians. OSM #11 and #16 were asked to review the menu. When asked what portion size of beef and ham the residents were to receive, OSM #11 stated, "Whetever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces engreened on the menu, OSM #11 stated, "Let us get back to you." When asked what poential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "I's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364  F 364  F 364  F 364  F 364	MANORO	LARE HEALIH SERV	ICES-KICHMOND			RICHMOND, VA 23228		
Review of the facility's menu documented, "BARBEQUE BEEF 3OZ (ounces) REG (regular diet) 4OZ. HAM W/ (with) PINEAPPLE 3OZ. REG 6OZ.  On 2/15/17 at 2:03 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing were made aware of the findings.  An interview was conducted on 2/15/17 at 2:30 p.m. with OSM #11 and #16, the dietitians. OSM #11 and #16 were asked to review the menu. When asked what portion size of beef and ham the residents were to receive, OSM #11 stated, "Whatever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "Its not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of near and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F.364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F.364  ATABLE (EDPECED TEM)	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
Review of the facility's menu documented, "BARBEQUE BEEF 3OZ (ounces) REG (regular diet) 4OZ. HAM W/ (with) PINEAPPLE 3OZ. REG 6OZ.  On 2/15/17 at 2:03 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing were made aware of the findings.  An interview was conducted on 2/15/17 at 2:30 p.m. with OSM #11 and #16, the dietitians. OSM #11 and #16 were asked to review the menu. When asked what portion size of beef and ham the residents were to receive, OSM #11 stated, "Whatever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "Its not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of near and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F.364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F.364  ATABLE (EDPECED TEM)	F 363	Continued From pa	nae 98	F3	363	•		,
"BARBEQUE BEEF 3OZ (ounces) REG (regular diet) 4OZ. HAM W/ (with) PINEAPPLE 3OZ. REG 6OZ.  On 2/15/17 at 2:03 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing were made aware of the findings.  An interview was conducted on 2/15/17 at 2:30 p.m. with OSM #11 and #16, the dietitians. OSM #11 and #16 were asked to review the menu. When asked what potential coisze of beef and ham the residents were to receive, OSM #11 stated, "Whatever is in the column (on the menu.) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F.364 483.60(d)(1/2) NUTRITIVE VALUE/APPEAR, F.364  JAMAN EPPEEPE TEMP			~	. `				
diet) 40Z. HAM W/ (with) PINEAPPLE 3ÔZ. REG 6OZ.  On 2/15/17 at 2:03 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing were made aware of the findings.  An interview was conducted on 2/15/17 at 2:30 p.m. with OSM #11 and #16, the dietitians. OSM #11 and #16 were asked to review the menu. When asked what portion size of beef and ham the residents were to receive, OSM #11 stated, "Whatever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "it's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR,  F 364  F 364								
member) #1, the administrator and ASM #2 the director of nursing were made aware of the findings.  An interview was conducted on 2/15/17 at 2:30 p.m. with OSM #11 and #16, the dietitians. OSM #11 and #16 were asked to review the menu. When asked what portion size of beef and ham the residents were to receive, OSM #11 stated, "Whatever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR,  F 364 ATABLE/ERPEFER TEMP		diet) 4OZ. HAM W/						
director of nursing were made aware of the findings.  An interview was conducted on 2/15/17 at 2:30 p.m. with OSM #11 and #16, the dietitians. OSM #11 and #16 were asked to review the menu. When asked what portion size of beef and ham the residents were to receive, OSM #11 stated, "Whatever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR,  F 364 474.81 EPPEFER TEMP								
findings.  An interview was conducted on 2/15/17 at 2:30 p.m. with OSM #11 and #16, the dietitians. OSM #11 and #16 were asked to review the menu. When asked what portion size of beef and ham the residents were to receive, OSM #11 stated, "Whatever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1/2) NUTRITIVE VALUE/APPEAR,  F 364 483.60(d)(1/2) NUTRITIVE VALUE/APPEAR,  F 364 F 364 483.60(d)(1/2) NUTRITIVE VALUE/APPEAR,  F 364 F 364 483.60(d)(1/2) NUTRITIVE VALUE/APPEAR,  F 364 F 364 483.60(d)(1/2) NUTRITIVE VALUE/APPEAR,								
p.m. with OSM #11 and #16, the dietitians. OSM #11 and #16 were asked to review the menu. When asked what portion size of beef and ham the residents were to receive, OSM #11 stated, "Whatever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  RECEIVED  MAR 0 9 2017  VDH/OLG  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR,  F 364 AS3.60(d)(1)(2) NUTRITIVE VALUE/APPEAR,  F 364 AS3.60(d)(1)(2) NUTRITIVE VALUE/APPEAR,  F 364 AS3.60(d)(1)(2) NUTRITIVE VALUE/APPEAR,			were made aware of the					
#11 and #16 were asked to review the menu. When asked what portion size of beef and ham the residents were to receive, OSM #11 stated, "Whatever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  RECEIVED  MAR 0 9 2017  VDH/OLG  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR,  P 364 ATABLE REPRESED TEMP								
When asked what portion size of beef and ham the residents were to receive, OSM #11 stated, "Whatever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR,  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR,  F 364 5 AND THE MERCE								
"Whatever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "it's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #5 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR,  PALATABLE/PREFER TEMP.		When asked what p	portion size of beef and ham					
be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you."  When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PDESED TEMP.  F 364 7 F 364 S 3/31/17								
ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PPEEFER TEMP.  F 364 5 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PPEEFER TEMP.  F 364 5 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364								
When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364  3/31/17		ounces and four ou	nces represented on the					
occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364  ATABI E/PREFER TEMP								
amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364  483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364  The part of the provided prior to exit.  F 364  ATABLE/PRESER TEMP.  F 364								
occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364  SCOLUBER 15/18/18/18/18/18/18/18/18/18/18/18/18/18/								
was, OSM #16 stated, "It's not very high."  On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364  SOLE PALATARI EXPRESER TEMP								
On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364  SCAL PALATARI E/PRESER TEMP.								
dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364  SCAL PALATARI E/PPEER TEMP								
met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364  PALATARI E/PRESER TEMP		dining services, OS	M #11 and #16, the dietitians			RECEIVED		
receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364  SCAL DAI ATABLE/PRESER TEMP						<del></del> <del></del>		, l
ounces of ham and the pineapple slice (which would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364  SC-F PALATARI E/PPEER TEMP		receive three ounce	s of meat and one ounce of			MAR U Y 2017		
would equal six ounces."  No further information was provided prior to exit.  F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364  SC-F PALATARI E/PRESER TEMP						VDH/QLG		
F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364						A MINISTER OF MAN AND MANUAL M		
F 364 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, F 364			•			F-364	3	3/31/17
				F3	364	It is the intended practice of the		

It is the intended practice of this

PRINTED: 02/28/2017 FORM APPROVED

CENTE	<u>RS FOR MEDICARE</u>	E & MEDICAID SERVICES			OMB N	<u>IO. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495045	B. WING_			C )2/15/2017
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		MINIEU:
	~ - ~ ~ : : m 4 } #11 @PM\/		-	2125 HILLIARD ROAD		•
MANUR	CARE HEALTH SERV	ICES-RICHMOND		RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHIP CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 364	Continued From pa	₃ge 99	F 36	prepared by methods that con	serve	3/31/17
	(d) Food and drink			nutritive value, flavor and appearance; and that food	is	1
		ives and the facility provides-		palatable, attractive, and at proper temperature.	the	
		ed by methods that conserve				
	nutritive value, flavo	or, and appearance;		Criteria 1		*:
	/d\/2\ Food and dri	ink that is palatable, attractive,	•	Upon notification from survey	or	
		appetizing temperature;	*	regarding temperature of test t	ray,	
		NT is not met as evidenced		CDM re-educated staff regard		
	by:			proper policies and procedures	;	
		tion, staff interviews and facility				
		it was determined that the o serve food at a palatable		•		
	temperature for res			related to proper serving temperature.	٠	
		led to serve food at a palatable lunch meal on 2/15/17.		Criteria 2		
				Any and all residents have the		
	The findings include	e:		potential to be affected.		
	3:00 p.m. with five r the food temperatur	reeting was held on 2/14/17 at residents. When asked about re and quality, the residents I was cold and the taste could		Criteria 3  All dietary staff to be re-educate regarding proper temperatures utilizing the tray audit tool and reviewing policy and procedure.	, 1	:
	made on 2/15/17 at temperatures were	he lunch tray preparation was t 11:05 a.m. Food taken by OSM (other staff director of dining services and		related to tray service and transport.		
	were as follows: roa	ast beef 188 degrees; grees; hot dog 165 degrees;		RECEIVED		
	chopped chicken 16	66 degrees; ham slice 183 legrees; mixed vegetables 158		MAR 0 9 2017		
		ef 178 degrees; pureed bread 169 degrees; ground beef		VDH/OLG .		

178 degrees; pasta 169 degrees; ground beef

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

— · · · · · · · · · · · · · · · · · · ·	
	ATE SURVEY OMPLETED
495045 B. WING 0	C 2/15/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
2125 HILLIARD ROAD	
MANORCARE HEALTH SERVICES-RICHMOND RICHMOND, VA 23228	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364 Continued From page 100 F 364 Criteria 4	3/31/17
165 degrees; mashed potatoes 164 degrees; Administrator or designee will cabbage 169 degrees; gravy 166 degrees and audit proper temperature of food	
barbeque sauce 204 degrees.  barbeque sauce 204 degrees.  using tray audit tool daily x3 for 2	
weeks, then once daily for	
On 2/15/17 at 12:12 p.m. the last food cart was following 2 weeks, 2x weekly on	
loaded with residents trays, a request was made	
to down who to propare a test tray. The lood eart	
was followed to the unit by OSM #15 and two surveyors. At 12:38 p.m. all of the residents' travs  Criteria 5	
surveyors. At 12:38 p.m. all of the residents' trays had been delivered and residents had begun  The facility's alleged date of	
eating. At that time the test tray food compliance is 3/31/2017.	
temperatures were re-checked by OSM #15. The	
food temperatures on the test tray were as	
follows: roast beef 133 degrees; hamburger 125	
degrees; hot dog 133 degrees; ham 113 degrees;	
rice 130 degrees; mixed vegetables 123 degrees, pureed beef 118 degrees; pureed bread 108	
degrees; pureed bread 123 degrees; pasta 108	
degrees; mashed potatoes 110 degrees and	
cabbage 128 degrees, chocolate ice cream 35	
degrees and vanilla ice cream 22 degrees.	
OSM #15 and the two surveyors tested the food.	
OSM #15 stated that he preferred his food cooler	
and did not mind the temperature; the two	
surveyors found most of the food to be too cool in	
temperature to be palatable but the taste of the food was very palatable. The ice cream was	
completely melted; it could be poured out of the	
container and tasted warm.	
An interview was conducted on 2/15/17 at 12:50	
p.m. with OSM #15. When asked what temperature he wanted food to be when delivered	***************************************
to the residents, OSM #15 stated, "140 degrees." MAR $0.9 2017$	
When asked why, OSM #15 stated, "Well the residents are always a little colder and like VDH/OLC	

warmer food."

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

(	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO. 0938-03</u>	91
		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			495045	B. WING			C 02/15/2017	
1	VAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ļ	MANOR	CARE HEALTH SERVI	CES-RICHMOND		l	25 HILLIARD ROAD ICHMOND, VA 23228		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTIO	ON
	F 364	TEMPERATURES adocumented, "Food attractive and at the determined by the transfer satisfaction Is foot temperatures (hot foods are served copatient and customs or range of temperatures defined in the regular Surveyors. Patient and consideration is	y's policy titled, "FOOD AT POINT OF SERVICE" I should be palatable, proper temperature as ype of food to ensure patient's od served at preferable cods are served hot and cold old) as discerned by the ary practice? A temperature atures at point of service is not acceptance is used as a guide is given to the time the food is between 135 (degrees) F	F3	364			
		p.m. with OSM #15 degrees noted in the temperatures should stated, "I think that's informed of the resistemperature of the we need to re-heat asked if food temperature	onducted on 2/15/17 at 1:50. When asked if the 41 e facility's policy on food d be 141 degrees, OSM #15 is for the cold food." When dent's concerns regarding the food, OSM #15 stated, "So, if it we should re-heat it." When eratures were tested at the isM #15 stated, "Not on a					
		member) #1, the ad	p.m. ASM (administrative staff Iministrator and ASM #2, the were made aware of the					
			on was provided prior to exit.	F3	387	F-387	3/31/17	,
		(c) Frequency of Ph	ysician Visits			It is the intended practice of this facility to ensure residents are	į	

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

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 102 of 134

RECEIVED

MAR 0 9 2017

VDH/OLG

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			OI	<u> VIB NO. 09:</u>	<u>38-0391</u>
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SU COMPLET	
	!				1	С	
		495045	B. WING_			02/15/2	2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	ICES-RICHMOND	1		125 HILLIARD ROAD		
**********	## 1 to 1 to 1 to 1 to 1 to 1 to 1 to 1		-	RI	ICHMOND, VA 23228	<del></del>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CO RIATE	(X5) IMPLETION DATE
F 387	Continued From pa	age 102	F 3	387	seen by a physician at least once every 30 days for the first 90 days	3/3	1/17
					after admission, and at least once		
		nust be seen by a physician at			every 60 thereafter.		
		days for the first 90 days after			- -	•	
	admission, and at it	east once every 60 thereafter.			Criteria 1		
		t is considered timely if it			0 00-2-2-2		
		nn 10 days after the date the	:		At the time of notification		
	visit was required.	in the second se			resident#13's physician visits were	· .	
		NT is not met as evidenced			up to date.		
	by: Based on staff inte	erview, facility document			O train 2		
		record review, it was			Criteria 2		
	determined that the	e facility staff failed to ensure			Any and all residents have the		
	timely physicians vi	isits for one of 29 residents in Resident #13.			potential to be affected.		į
	the our roy continue,	Nonce in the second sec			Criteria 3		
		ne physician visited on 5/24/16	ĺ		Medical records director and		
		/28/16, approximately 96 days in not again till 11/13/16, ays between visits			Physician involved will be re-		-
	approximatory is a	ayo betatoon alone.			educated to ensure timely		
	The findings include	e:			physician visits.		
	- 11 1110				physician vicini		
		admitted to the facility on			Criteria 4		
		agnoses of but not limited to is, depression, anxiety, and			Administrator or designee will		
		e. The most recent MDS			audit physician visits daily x5		
		t) was a quarterly assessment			days, three times weekly x3 weeks	,	
	with an ARD (Asses	ssment Reference Date) of			and monthly x2 months.		
		dent was coded as being			and more -		
		impaired in ability to make			Criteria 5		
		The resident required total			The facility's alleged date of		
		sing, limited assistance for			compliance is 3/31/2017.		
		continent of bowel and bladder.			COMPTONIO 22 C.		
	<b>.</b>	ical record revealed the					

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

physician visited on 5/24/16 then not again till 8/28/16, approximately 96 days between visits;

Event ID: ODYV11

RECEIVED

If continuation sheet Page 103 of 134

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONS	STRUCTION		(X3) DATE SURVEY COMPLETED	
		495045	B. WING			ı	C /15/2017	
	PROVIDER OR SUPPLIER			2125 HIL	ADDRESS, CITY, STATE, ZIP CODE LLIARD ROAD OND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO PROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 387	days between visits On 2/15/17 at apprinterview with OSM the unit secretary, records, OSM #5 s locate any evidence Resident #13 in the A review of the policand Documentation "patients are seen of admission, even after admission an thereafter or per st a physician visit is within 10 days of the	1/13/16, approximately 77 s.  roximately 11:00 a.m., in an 1/45 (Other Staff Member #5) who was filling in for medical stated that she was unable to e that any visit occurred for e questioned time frames.  icy, "Monitoring Physician Visits in" documented, by a physician within 30 days y 30 days for the first 90 days d at least once every 60 days	F 3	87				
F 431 SS=D	On 2/15/17 at 2:00 (Administrative Sta aware of the finding provided by the endas.45(b)(2)(3)(g)(LABEL/STORE DF)  The facility must prodrugs and biologicathem under an agres §483.70(g) of this punicensed personal law permits, but on supervision of a lice (a) Procedures. A pharmaceutical serior state of the supervision of the supervisi	the Administrator  off Member #1) was made  gs. No further information was  d of the survey.  h) DRUG RECORDS,  RUGS & BIOLOGICALS  rovide routine and emergency  als to its residents, or obtain  eement described in  part. The facility may permit  nel to administer drugs if State  sly under the general	F 4	It is fac serv to ste	F-431  s the intended practice of the cility to employ or obtain the vices of a licensed pharmactore all drugs and biological ordance with state and federals.	he cist al in	3/31/17	

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

Event ID: ODYV11

RECEIVED

If continuation sheet Page 104 of 134



PRINTED: 02/28/2017

		& MEDICAID SERVICES			C		0. 0938-039
STATEMENT C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		DINSTRUCTION		TE SURVEY MPLETED
		495045	B. WING			02	2/15/2017
	ROVIDER OR SUPPLIER ARE HEALTH SERV	CES-RICHMOND		2125	ET ADDRESS, CITY, STATE, ZIP CODE HILLIARD ROAD IMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
			T T	<del> </del>		3	/31/17

#### F 431 Continued From page 104

dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

- (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--
- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and
- (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
- (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.
- (h) Storage of Drugs and Biologicals.
- (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.
- (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can

#### Criteria 1 F 431

Upon notification from surveyor, all tubes of medicated creams were removed from resident#14's room and stored in medication cart.MD was notified and orders obtained to leave medicated creams and nystatin powder at bedside medication stored in the locked compartment.

### Criteria 2

Any and all residents have the potential to be affected.

#### Criteria 3

The nursing staff will be reeducated on the proper storage of drugs and biologicals in accordance to state and federal law to ensure that all resident needs are met.

#### Criteria 4

DON or designee will audit resident rooms to ensure proper Storage daily x5 days, three times weekly x3 weeks and monthly x2 months.

#### Criteria 5

The facility's alleged date of compliance is 3/31/2017.

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

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 105 of 134

RECEIVED

MAR 0 9 2017

VDH/QLG

PRINTED: 02/28/2017 FORM APPROVED OMB NO 0938-0391

CENTE	RS FUR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495045	B. WING		C 02/15/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Æ
MANORO	CARE HEALTH SERV	CES-RICHMOND		2125 HILLIARD ROAD	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE COMPLETION
F 431	by: Based on observation interview, facility do record review, it was taff failed to store manner for one of 2 sample, Resident #	NT is not met as evidenced ion, resident interview, staff cument review and clinical s determined that the facility medications in an appropriate 29 residents in the survey 14.  edicated cream were ik in Resident #14's room on	F 4	l31 ·	
	4/27/12. Resident a were not limited to: (stroke), chronic pa pressure. Resident (minimum data set) an ARD (assessme coded the resident a Section G coded Resupervision with one bed mobility, transferesident was coded person physical ass supervision with set hygiene.  Resident #14's curredocumented orders benzoyl peroxide (1 applied to the resident.	idmitted to the facility on #14's diagnoses included but cerebrovascular disease in syndrome and high blood #14's most recent MDS, a quarterly assessment with nt reference date) of 1/27/17, as being cognitively intact. esident #14 as requiring e person physical assist with ers, eating and toilet use. The as requiring limited one ist with dressing and up help only with personal ent physician order summary including but not limited to: ) 5% gel to be topically ent's scalp lesions every day, 100,000 unit/one gram to be		RECEIVED MAR 0 9 2017 VDH/QLC	

applied to the resident's groin twice daily as

PRINTED: 02/28/2017 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495045	B. WING	;_		ŀ	C 15/2017	
NAME OF I	PROVIDER OR SUPPLIER	M			STREET ADDRESS, CITY, STATE, ZIP CODE			
MANOR	CARE HEALTH SERV	CES-RICHMOND			2125 HILLIARD ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 431	applied four times of hemorrholds. Ther order for nystatin coream (5).  Resident #14's condon 2/8/17 document Rash at groin areast treatment per physialteration in skin intimpaired mobility. Illusions to scalpIndictional orders" The document information medicated creams.  On 2/14/17 at 11:04 the facility, multiple were observed on Illustration in wheelchair in his Four tubes of medical on Resident #14's stitling in a wheelch resident's permissificant tubes of medical the resident's sink.	zone (3) 2.5% cream to be daily as needed for re was no current physician's ream (4) or triamcinolone reprehensive care plan revised ated, "Focus: Recurrent YeastInterventions: Administer ician ordersFocus: At risk for tegrity related to: incontinence, Resident has reoccurring atterventions: Apply resident scalp per md (medical rich care plan failed to ion regarding storage of tubes of medicated cream Resident #14's sink.  p.m., Resident #14 was sitting is room watching television. cated cream were observed		43	RECFIVED			

KECEIVED

MAR 0 9 2017

VDH/OLG

and one 1/2 full tube of Nystatin 100,000 unit/one gram cream. Resident #14 stated the creams

were for his groin and he learned how to mix the

-One 1/3 full tube of benzoyl peroxide 5% gel and one 3/4 full tube of Proctozone 2.5% cream.

creams up and put them on himself.

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			OMB NC	<u>0. 0938-0391</u>
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DA	TE SURVEY
		495045	B. WING_			C 2/15/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
MANOR	CARE HEALTH SERV	NCES DICHMOND		2125 HILLIARD ROAD		
WAINCH.	UARE HEALIN VEIX	ICEG-IXIO INICIAD		RICHMOND, VA 23228		
(X4) ID PREFIX TAG	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE  X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	Continued From pa	age 107	F 4:	31		
-	•	ed he used those creams for	•			
	lesions on his head					
		wo plastic spoons with dried				
		0 a.m., an interview was				
		N (licensed practical nurse) #1 lirse). LPN #1 was asked about	4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4			
		for storage of medicated	*			
	creams and resider	nt self-administration of				
		. LPN #1 stated medicated tored in the treatment cart but	· 1			
		a physician's order to keep the				
	medication at the b	pedside. At this time, LPN #1				
		his surveyor observed	*			
		in Resident #14's room and he had been applying the				
	creams himself. LF	PN #1 stated Resident #14's				
		should have been kept in the	:			
		should not have been in the cause she thought the resident	3			
		der to keep the creams at the				
		p.m., ASM (administrative				• .
		the administrator) and ASM #2 sing) were made aware of the				
	above concern.	sing) were made aware or the				
		tled, "MEDICATION I: TOPICAL" documented the		RECEIVED		
	procedure for topical	al medication administration		MAR 0 9 2017		
	and documented, " medication cart"	12. Return medication to		MILIOLO		
		tion was presented prior to exit.		ADH/OFG		İ
	NO IUIUIOI RECENSA	Off was presented prior to exit.				ļ
		de is used to treat acne and ns. This information was				

DEPARTMENT OF HEALTH AND HUMAN SERV	VICES
CENTERS FOR MEDICARE & MEDICAID SERV	/ICES

PRINTED: 02/28/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMR M	<i>).</i> 0 <u>938-0391</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	TIPLE CONS	STRUCTION	(X3) DATE SURVEY COMPLETED		
:		495045	B. WING			02/15/2017		
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
MANORO	CARE HEALTH SERV	ICES DICUMOND		2125 HII	LLIARD ROAD			
MANORU	ARE HEALIH SERV	ICES-RICHMOND		RICHM	OND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ALD BE	(X5) COMPLETION DATE	
F 431	Continued From pa	age 108	, F	131				
	obtained from the v	<del>-</del>						
		m.nih.gov/pubmedhealth/PMH	`					
	infections. This infethe website:	is used to treat fungal ormation was obtained from .gov/druginfo/meds/a682758.h	;					
	swelling caused by information was ob https://dailymed.nlr	sed to treat itching and hemorrhoids. This tained from the website: n.nih.gov/dailymed/fda/fdaDru 6746ff-3ff1-4874-a827-469413	имент					
	infections. This infethe website:	is used to treat fungal ormation was obtained from .gov/druginfo/meds/a682758.h	· i					
	and inflammation of was obtained from	s used to treat itching, redness of the skin. This information the website: .gov/druginfo/meds/a601124.ht	4 3 3 3 5 5 5 6 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7					
F 441 SS=E		e)(f) INFECTION CONTROL, D, LINENS	F	141	F-441		3/31/17	
	(a) Infection prever	ntion and control program.		fac	is the intended practice of the cility to establish and mainte an infection control progran	ain		
		stablish an infection prevention (IPCP) that must include, at lowing elements:		en	designed to provide a safe, sanitary, and comfortable vironment and to help preve	ent		
	(1) A system for pro	eventing identifying reporting		the	development and transmiss	ion		

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

(1) A system for preventing, identifying, reporting,

Event ID: ODYV11

Facility ID: VA0241

of disease and infection.

If continuation sheet Page 109 of 134

### RECEIVED

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

OCIVICIO I ON MICOIOA	IL G MEDICAID SEIVICES			<u> </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	(X3) DATE SURVEY COMPLETED	
,	495045	B. WING		C 02/15/2017
NAME OF PROVIDER OR SUPPLI	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE	
MANORCARE HEALTH SEI	RVICES-RICHMOND		2125 HILLIARD ROAD RICHMOND, VA 23228	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRICIENCY)	JLD BE COMPLETION
		1		3/31/17

#### F 441 Continued From page 109

investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

- (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
- (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
- (ii) When and to whom possible incidents of communicable disease or infections should be reported;
- (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
- (iv) When and how isolation should be used for a resident; including but not limited to:
- (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
- (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
- (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct

#### F 441

Criteria 1

Upon notification, licensed nurse involved was re-educated on proper sanitation of the glucometer, remove gloves while in the room and perform hand hygiene and medication carts involved were properly sanitized. Resident #18's MD and RP were notified and incident report filed Resident #29 MD and RP were notified and incident report filed All linen was re-washed after cleaning the air vents and fans.

#### Criteria 2

All residents receiving blood sugar checks have the potential to be affected. All residents have the potential to be affected with improper linen handling.

#### Criteria 3

All licensed nurses will be reeducated on infection control practices for obtaining residents blood sugar. All individual who process, handle and clean linen will be re-educated on infection control practices involving what constitutes clean linen and proper handling and maintaining of clean air vents

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

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 110 of 134

RECEIVED

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		<del></del>	U	MR M	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				ATE SURVEY OMPLETED
	·	495045	B. WING	·		0	C )2/15/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	125 HILLIARD ROAD		
MANORO	CARE HEALTH SERVI	CES-RICHMOND		F	RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	contact will transmit  (vi) The hand hygie by staff involved in contact will transmit (4) A system for recounder the facility's I actions taken by the (e) Linens. Personal process, and transpared of infection.  (f) Annual review. I annual review of its program, as necess This REQUIREMENT by:  Based on observative record review, it was staff failed to process anitary manner and control practices duadministration observations.	nts or their food, if direct to the disease; and the disease; and the procedures to be followed direct resident contact.  cording incidents identified PCP and the corrective efacility.  In a must handle, store, port linens so as to prevent the facility will conduct an IPCP and update their sary.  It is not met as evidenced ion, staff interview and clinical is determined that the facility is and store linens in a difficulty facility in a difficulty of two of five dication administration		141	Criteria 4  DON or designee will audit daily x5 days, three times weekly x3 weeks and monthly x2 months to ensure proper infection control practices in these areas  Criteria 5  The facility's alleged date of compliance is 3/31/2017.		3/31/17
	the floor when trans failed to keep air ve folding and storing of	failed to keep clean linens off porting and folding them and nt and fans free of dust when clean linens.  ailed to follow infection control		R	ECEIVED		
		ng resident blood sugar		Å,	MAR 0 9 2017		
		medication administration		į ¥	IMIN U J ZUII		

observation for Resident #18 and Resident #29.

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				O	VIB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION			E SURVEY MPLETED
		495045	B. WING				ŀ	С
		493049	D. WING				02/	15/2017
NAME OF	PROVIDER OR SUPPLIER			l	REET ADDRESS, CITY, STATE, ZI	IP CODE		
MANOR	CARE HEALTH SERVI	CES-RICHMOND		i	25 HILLIARD ROAD			
	,		<del></del>	- Ri	CHMOND, VA 23228	<del> </del>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF I (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD HE APPROPE	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 111	F	141				
	The findings include	•	•	• • •				
	The mange mode	•						
	the floor when trans	failed to keep clean linens off porting and folding them and nt and fans free of dust when clean linens.	3 .					,
	facility's laundry roo laundry room consist contained commerce linens and soiled reseparate room adjactontained four commerce four clothes racks for an observation of the facility's laund Observation of the facility's laund Observation of the facility's laund Observation of the facility's laund Observation of the facility's laund Observation of the facility's laund Observation of the facility's laund Observation of the facility's laund Observation of the facility's laund Observation of the facility's laund Observation of the facility's laund of the facility's laund Observation of the facility is laund of the facil	a.m. an observation of the m was conducted. The sted of a dirty linen room that sial clothes washer and soiled sident clothing. Another cent to the soiled linen room mercial clothes dryers and or residents' clean clothing. The facility's clothes dryer room dry room was conducted. Four clothes racks revealed four clothes racks revealed four clothes racks revealed for esident's clean clothing s. Further observation of the eled them to be open and ervation of the ceiling in the revealed two circular air vents ches in diameter with cool air nts. Further observation of the vents were covered with rown rust. A third separate ean linen folding room, it room contained two six foot able top fan on them.						
	Further observation	of the clean linen folding		F	RECEIVED			
		dryer room revealed one of			MAN O O OAM			İ
		perating and blowing air from to forward. OSM (other staff			MAR 0 9 2017			
		sekeeper, was observed in		•				1

this room standing at the front of the table. The fan was blowing in the direction of OSM # 2 as they were folding clean blankets and setting them

PRINTED: 02/28/2017

		I AND HUMAN SERVICES  E & MEDICAID SERVICES				M APPROVED 0. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA (X2) M		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495045	B, WING		02	C 2/15/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 2125 HILLIARD ROAD RICHMOND, VA 23228	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	Continued From pa	age 112	F	141			

On 02/15/17 at 8:25 a.m. OSM # 3, the environmental supervisor, was observed removing clean linen from clothes dryers into a laundry bin. While OSM #3 was removing the linen from the dryer, several pieces of linen fell out of the dryer onto the laundry room floor. OSM # 3 pick the linen up off the floor and placed them into the linen bin with the rest of the clean linen that was removed from the dryer. OSM # 3 then took the bin of clean linen into the clean linen folding room. OSM # 3 removed the clean linen from the bin and placed it in a pile on the table in front of the fan blowing across the table. OSM # 3 then proceeded to fold numerous pieces of linen in front of the fan. Further observation of OSM # 3 folding the linen revealed that while she was folding blankets OSM # 3 allowed sections of

the blankets to fall onto the floor before lifting the sections up from the floor and folding them. OSM #3 then placed the folded blankets with the rest of

the clean linens on the table in front of the

on the table in the direction of the blowing fan.

On 02/15/17 at approximately 8:35 a.m. an interview was conducted with OSM # 1, director of housekeeping and OSM # 3, environmental supervisor. When asked about the linens being dropped on the floor while they were being removed from the dryer OSM # 3 stated, "I don't remember that but if they did they should have been rewashed." When asked about sections of the blankets being dropped to the floor while OSM # 3 was folding them, OSM # 3 stated, "They didn't touch the floor that long." OSM #1 stated that if any of the clean laundry falls to the floor or touches the floor while being folded, they should be rewashed immediately. When asked

RECEIVED

MAR 0 9 2017

VDH/OLG

blowing fan.

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FUR MEDICARE	= & MEDICAID SERVICES				MB NO. 0	<u>938-0391</u>	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495045	B. WING	;		C 02/15	5/2017	
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		765-41,	
	~-~-·	TOTO BIOLISIAN	1	1	125 HILLIARD ROAD			
MANORU	CARE HEALTH SERVI	ICES-RICHMOND		R	RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE . C	(X5) COMPLETION DATE	
F 441	Continued From pa	age 113	F 4	441	<del>;</del>			
	·	of cleaning the fans and air	• -	Y-7 ,				
	vents OSM # 1 and	OSM # 3 stated that they are	1					
		I. OSM # 1 was asked to turn	1					
		that was blowing in the clean						
	linen folding room.	An examination of the fan					İ	
		d by OSM # 1 and OSM # 3.						
		fan was clean, OSM # 1 and	•					
		and agreed the fan blades	=					
		re covered in brown dirt and	-					
		if the clean linens should have						
		t of the dirty table top fan, lo." When informed of the						
		iM # 2 and OSM # 3 folding						
		t of the dirty fan while it was				-		
		stated, "The linens should						
		ed and the fans cleaned."	<u>:</u>					
		asked to observe the ceiling						
		othes racks in the dryer room.						
		e ceiling air vents OSM # 1						
	agreed there was ru	ust on them and the vents						
		ust. OSM # 1 further stated	:					
	that the resident clo covered.	othing racks should have been				•		
	documented, "Policy clean and disinfect t	7.2 Laundry Room Cleaning" by Directives: Laundry staff will the Laundry Room on a daily res. Dust or vacuum: Floor	:					
		C (air conditioning) Vents.						
		roximately 3:15 p.m. ASM			RECEIVED			
	(administrative staff				MAD OO AND			
	administrator, was n	made aware of the findings.			MAR 0 9 2017			
	No further information	on was provided prior to exit.			ADH/OFC			

2. The facility staff failed to follow infection control

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/28/2017 FORM APPROVED

_CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	IO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION PING		DATE SURVEY COMPLETED
		495045	B. WING			C 02/15/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
MANOR	CARE HEALTH SERV	ICES-RICHMOND		2125 HILLIARD ROAD		
				RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 114	F 4	· 141		
		ing resident blood sugar				
		medication administration sident #29 and Resident #18.	:			
	Resident #29 was a	admitted to the facility on		·		
	1/10/17 with diagno	ses that included but were not	:			
		of the brain, intracranial mentia, high blood pressure,				
	and muscle weakne					
	The most recent MI	OS (minimum data set)				
	assessment, an admission assessment, with an assessment reference date of 1/17/17, coded the					
		oderately impaired to make				
•	cognitive daily decis	sions. The resident was	:			
		limited to extensive assistance members for her activities of	Allow a frame			
	daily living.	menibers for their activities of	1			
		dated, 1/11/17 and signed by	:			
	rapid acting human	insulin (1)) 100UNIT/ML				
		cutaneously before meals sliding scale for blood sugar -				
		ts subQ (subcutaneously);				
		ts subQ; 250 - 299 give 6	)			
		19 give 8 units subQ, 350 - bQ; 400 + or < (less than) 50				
		ctor) for DM (diabetes				
	,	alamitet and American Electric				
	8/11/16 with diagnos	dmitted to the facility on ses that included but were not		RECEIVED		land vermanana
	Wernicke's encepha	heart failure, dementia, and alopathy (an inflammatory,		MAR 0 9 2017		
	•	e of the brain characterized k of coordination and				
	decreased mental s			<b>ADHIOLG</b>		

decreased mental status (2))

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-03	391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495045	B. WING	;		C 02/15/2017	
	PROVIDER OR SUPPLIER  CARE HEALTH SERVI	CES-RICHMOND		2125	EET ADDRESS, CITY, STATE, ZIP CODE 5 HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETI	ON
F 441	The most recent MI assessment, a quarassessment referer resident as being m daily decisions. The requiring limited to estaff member for he The physician order by the physician on "Novolog (short acti (milliliters); inject 5 to breakfast, with lunct 0 - 250 = 0; 251 - 30; 350 = 4 units; 351 - units; 451 - 500 = 10 higher) give 12 units for DM (diabetes me Observation was ma LPN (licensed practi	DS (minimum data set) terly assessment, with an accedate of 1/26/17, coded the oderately impaired to make a resident was coded as extensive assistance of one ractivities of daily living.  Is dated, 11/22/16, and signed 2/12/17, documented, and insulin (3)) 100UNIT/ML units subcutaneously with an, with dinner if (blood sugar) to 2 units (of insulin); 301 - 400 = 6 units; 401 - 450 = 8 to units; 501 + (501 and and call MD (medical doctor)		441			
	The glucometer (masugar by finger stick of the medication cause hand sanitizer of the glucometer, glowand lancet (an instruobtain blood for the clean the glucometer Resident #29's room supplies on the over gloves, wiped the reswab. LPN #9 then I and was observed s	ichine to check the blood ) was observed sitting on top irt. LPN #9 was observed to in her hands. She gathered res, alcohol swab, testing strip iment to lance the skin to blood sugar). She did not ir prior to entering the in. LPN #9 placed the bed table. She put on her sident's finger with an alcohol anced Resident #29's finger, queezing the resident's finger issting. There was not enough	:		RECEIVED  MAR 0 9 2017  VDH/OLC		TAN A MARIAN MARIAN MARIAN MARIAN MARIAN MARIAN MARIAN MARIAN MARIAN MARIAN MARIAN MARIAN MARIAN MARIAN MARIAN

blood to do the test. LPN #9 walked out of the room to the medication cart, with gloves on. Opened the bottle of testing strips and got

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u> </u>	MB NO.	0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ISTRUCTION		(X3) DAT	E SURVEY IPLETED
		495045	B. WING				l	C 1 <b>5/2017</b>
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-RICHMOND		2125 HII	ADDRESS, CITY, STATE, ILLIARD ROAD IOND, VA 23228	ZIP CODE	( <u> </u>	13/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 441	another test strip or alcohol swab and p #29's room. She n used any form of his proceeded to perfortesting. She then in her used supplies a appropriate recepta Resident #29's room on top of the medicusing hand sanitize placed the glucomethe medication cart glucometer.  LPN #9 then moved next resident room, removed the glucor cart drawer and plashe gathered her since Resident #18's room the bedside table. Lobtain Resident #18 glucometer back on then gathered her ungloves and washed glucometer back to placed it on top of the	art. She then grabbed another proceeded back into Resident ever discarded the gloves or and sanitation. LPN #9 rm the resident's blood sugar emoved her gloves, gathered and emptied them in the acle. LPN #9 then exited m, and placed the glucometer ation cart. She was observed or on her hands. LPN #9 then exter inside the top drawer of the she had not clean the she had a top the proceeded to the glucometer out of the medication ced it on the top of the cart. She put the glucometer on the proceeded to the she had sugar. She put the sed supplies, removed her her hands. She then took the the medication cart and the cart. LPN #9 then cleaned a wipe made for cleaning the	F 4	41				
	nurse) #6 on 2/15/1 how often a nurse s	nducted with RN (registered 7 at 10:20 a.m. When asked hould clean a glucometer ted, "You have to clean it the patient."		W	ECEIVED AR 0 9 2017 DH/OLC			

An interview was conducted with LPN #9 on 2/15/17 at 2:45 p.m. The observation of LPN #9

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	·····		OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495045	B. WING		C 02/15/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MANOR	DADE HEALTH CEDVE	CEC DICHMOND	İ	2125 HILLIARD ROAD	
WANCK	CARE HEALTH SERVI	CES-RICHWICHD		RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	ILD BE COMPLETION
F 441	Continued From pa	ge 117	F4	, .41	
	•	ay without changing gloves	• -	· · ·	
		est strip from the bottle and			
		cometer was shared at this			
		d, "I did go in the hallway			
		y gloves and that's correct. I			
		t was too late to correct it."			
		cleaned the glucometer #29 and Resident #18), LPN			
		n't do it between them but			
		t after (Resident #18).			
	An interview was co	enducted with RN #3, the unit			
	manager, on 2/15/1	7 at 3:00 p.m. RN #3 was		•	
		ve observation of LPN #9			
		ar readings for Resident #18			
		and asked if LPN #9 had ontrol practices. RN #3			
		ould have ungloved before			
		ed (medication) cart and used			,
		shed her hands. She should			***
		e hallway with dirty gloves."			
		ften the glucometer is to be			
	resident."	ed, "Before and after each			
		Slucose Blood Monitoring			
		Sugar)" documented in part,			
		blish clean field. Unfold and r towel on over bed table or			
	• • •	ce. Place equipment on top			
		pply latex free non-sterile		RECEIVED	
		lood glucose meter utilizing		WEAR! A PRICE	
		ntal protection agency)		MAR 0 9 2017	
		be or approved germicidal			
	disinfectant per the 19. Remove gloves	manufacturer instructions.		ADHIOLG	
		and perform hand n equipment to designated			
		and disinfection. Discard			

disposable supplies."

PRINTED: 02/28/2017

		THE PROPERTY OF LANCES			FURM APPRUVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495045	B. WING		C 02/15/2017
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
*****		oco piormono	1	2125 HILLIARD ROAD	
MANORO	CARE HEALTH SERVI	CES-RICHMOND		RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETION
F 441	Continued From pa	ge 118	F 4	41	
	used by LPN #9 doprofessionals should the Assure Platinum taking off gloves. Operatial infection ridisinfecting the met Cleaning and disinfecting a commercial disinfectant deterge a wipe, remove from label instructions to extreme care not to key code ports of the both a cleaner and visibly present on the contract of	for the type of glucometer cumented in part, "Healthcare d wear gloves when cleaning in meter. Wash hands after contact with blood presents a sk. We suggest cleaning and er between patient use. ecting can be completed by ly available EPA - registered ent or germicide wipe. To use in container and follow product disinfect the meter. Take get liquid in the test strip and ite meter. Many wipes act as disinfectant, though if blood is the meter, two wipes must be to clean and a second wipe to			
	blood glucose monitadministration of the requirements:  "Finger stick development than one pers "Whenever possishould not be share device should be cleavery use, per manufacturer does	persons who assist others with toring and/or insuling following infection control vices should never be used for on sible, blood glucose meters and. If they must be shared, the eaned and disinfected after ufacturer's instructions. If the not specify how the device and disinfected then it should		RECEIVED	
	The administrator w	ras made aware of the above		VECEIVED	

website:

concern on 2/15/17 at 3:28 p.m.

(1)This information was taken from the following

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495045	B. WING _		02	C 2 <b>/15/2017</b>
	PROVIDER OR SUPPLIER	ICES-RICHMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD	1 02	310/2017
				RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 119	F 44	<b>41</b>		
	m?setid=b34cd3ff-(2) Barron's Diction Non-Medical Reade Chapman; page 61 (3) This information website: https://dailymed.nlm m?setid=3A1E73A2 56FC5 (4) This information following website:	n.nih.gov/dailymed/druglnfo.cf d0af-4852-b4ef-2a8b4a93aeae ary of Medical Terms for the er 5th edition, Rothenberg and 1. was taken from the following n.nih.gov/dailymed/druglnfo.cf 2-3009-40D0-876C-B4CB2BE was obtained from the //injectionsafety/blood-glucose				
	483.70(i)(1)(5) RES	ETE/ACCURATE/ACCESSIB	F 51	4 F-514	3	/31/17
	(i) Medical records. (1) In accordance we standards and prace maintain medical reare- (i) Complete; (ii) Accurately documents (iii) Readily accessification (iv) Systematically of (5) The medical recomplete (ii) Sufficient information (iii) Sufficient information (iii) Sufficient information (iii) Sufficient information (iii) Sufficient information (iiii) Provided (iiii) Sufficient information (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	rith accepted professional tices, the facility must cords on each resident that mented; ble; and organized		It is the intended practice of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are—(i) complete (ii) Accurately documented; (ii) Readily accessible; and (iv) Systematically organized. It is a the intended practice of this facility to ensure the clinical record contains (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The plan of care and services provided; (iv) The results of an preadmission screening conduct by the State; and (v) Progress	e; i) lso e e vy eed	

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

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 120 of 134

RECEIVED

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTENO FOR MEDICANE	S MICDICAID SELVICES	****		OMB NO. 083	8-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	495045	B. WING		C 02/15/2	017
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERV	NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-RICHMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COM	(X5) APLETION DATE
		· · · · · · · · · · · · · · · · · · ·			

F 514

#### F 514 Continued From page 120

- (iii) The comprehensive plan of care and services : provided;
- (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State:
- (v) Physician's, nurse's, and other licensed professional's progress notes; and
- (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain a complete and accurate clinical record for four of 29 residents in the survey sample, Resident #6, Resident #1, Resident #17 and Resident #5.

- 1. For Resident #6, facility staff failed to document blood pressures in the clinical record prior to the administration of Hydralazine [1] 25 mg (milligrams) during December 2016 and January 2017.
- 2. a. The facility staff failed to document Resident #1's responsible party was notified regarding a room change on 1/6/17.
- b. The facility staff failed to document pain assessments and non-pharmacological interventions provided to Resident #1 with administration of as needed pain medication for multiple dates in December 2016 and January 2017.
- 3. The facility staff failed to document non

Criteria 1

3/31/17

At the time of the notification from surveyor, resident#6's blood pressure parameters had been clarified and discontinued by MD Resident#6's MD has been notified of not documenting blood pressures before administration of b/p meds in December and January. Staff has followed up with resident #1's responsible

party and documented the notification of the resident's room change, no concern noted Residents #1 has been assessed for use of pain medication and found it necessary to continue at prn basis, care plans have been up dated to include nonpharmacological interventions before use of prn pain medications. Resident #17 has been assessed for use of pain medication and found it necessary to continue at prn basis, care plans have been up dated to include nonpharmacological interventions before use of prn pain Other resident's lab result was removed from resident #5's chart and filed appropriately.

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

Event ID: ODYV11

Facility ID: VA0241

If continuation sheet Page 121 of 134

RECEIVED

VDH/OLC

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICAL	KE & MEDICAID SEKVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495045	B. WING	C - <b>02/15/2017</b>
NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STA 2125 HILLIARD ROAD RICHMOND, VA 23228	ITE, ZIP CODE
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE TAG CROSS-REFERENCED	N OF CORRECTION (XS) E ACTION SHOULD BE COMPLETION O TO THE APPROPRIATE DATE
			3/31/17

#### F 514 Continued From page 121

pharmacological interventions provided, the pain assessment when administering as needed (PRN) medication to Resident #17 and failed to document follow up on the effectiveness of the medication administered on 2/14/17.

4. The facility staff filed another resident's laboratory results on Resident #5's clinical record.

#### The findings include:

1. For Resident #6, facility staff failed to document blood pressures in the clinical record prior to the administration of Hydralazine [1] 25 mg (milligrams) during December 2016 and January 2017.

Resident #6 was admitted to the facility on 7/23/2008 and readmitted on 4/7/16 with diagnoses that included but were not limited to paraplegia, muscle weakness, type two diabetes, high blood pressure, and chronic pain. Resident #6's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/8/16. Resident #6 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #6 was coded as requiring extensive assistance from one staff member with transfers. toileting, and bathing; limited assistance from one staff member with dressing, and personal hygiene; and independent with meals.

Review of Resident #6's POS (Physician Order Sheet) signed by the physician on 1/30/17 documented the following order: "Hydralazine HCL 25 mg (milligram) Tablet 1 tab (tablet) by

#### F 514

#### Criteria 2

Any and all residents have the potential to be affected.

#### Criteria 3

The interdisciplinary team will be re-educated on a complete individualized clinical record keeping.

Licensed nurses will be reeducated on the facility pain guide to include assessing resident, offer non-pharmacology interventions before and after pain medication administration. And document effectiveness following interventions.

#### Criteria 4

DON or designee will audit charts and MARs dailyx5days, three days a week x3weeks and then monthly x2months.

#### Criteria 5

The facility's alleged date of compliance is 3/31/2017.

### RECEIVED

MAR 0 9 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	= & MEDICAID SERVICES				OMB N	<del>NO. 0938-</del> 0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION G	(X3) [	DATE SURVEY COMPLETED
		495045	B. WING	3	<u> </u>	ī	C <b>02/15/2017</b>
NAME OF I	PROVIDER OR SUPPLIER		-1	8	STREET ADDRESS, CITY, STATE, ZIP COL		V2, 14/24.
MANOR	CARE HEALTH SERV	POTO DICUISONO	1	2	2125 HILLIARD ROAD		
MANON	JAKE REALITE SERV	ICES-KICHMOND		F	RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	age 122	· F!	514	' 1		····
	mouth every 8 hour	rs; Hold for Blood Pressure This order was initiated on		•••	•		
	Administration Rec "Hydralazine HCL 2 every 8 hours, Hold	ember 2016 MARS (Medication cord) documented the following: 25 mg Tablet 1 tab by mouth d if Blood Pressure less than ration times for Hydralazine .m., and 10 p.m.					
	that Resident #6's b	ember 2016 MARS revealed blood pressures were not e 6 a.m. and 2 p.m. dose onth of December.					
	documented the following Tablet 1 tab by a Blood Pressure less times for Hydralazin	t #6's January 2017 MARS flowing: "Hydralazine HCL 25 mouth every 8 hours, Hold If s than 100/60." Administration he were at 6 a.m., 2 p.m., and er was discontinued on					•
	Resident #6's blood documented for the	ary 2017 MARS revealed that I pressures were not 6 6 a.m. and 2 p.m. dose from anuary 13th when the order	7 · · · · · · · · · · · · · · · · · · ·				
	failed to show evide	esident #6's clinical record ence that his blood pressures ented at 6 a.m. and 2 p.m.	R	C	CEIVED		
		a.m., an interview was	and the same of th	MAF	R 0 9 2017		
		V (licensed practical nurse) #2.					
		about the process followed by	V	/U	)H/OLG		

staff prior to administering a blood pressure medication. LPN #2 stated that if the order has

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DA	TE SURVEY
		495045	B. WING		_0;	C <b>2/15/2017</b>
	PROVIDER OR SUPPLIER  CARE HEALTH SERVI	ICES-RICHMOND	212	REET ADDRESS, CITY, STATE, ZIP CODE 25 HILLIARD ROAD CHMOND, VA 23228		**************************************
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 514	parameters, that sh pressure immediate blood pressure med would either hold th medication dependi reading. When ask should be document When asked where would be document would be document stated that she did n When asked if she blood pressure read #6, LPN #2 stated that the been taken but not a "That I don't know."	ne would take the blood ely before administering the dication. LPN #2 stated she he medication or administer the ling on the blood pressure readings at the line of the line o	t			
	conducted with LPN the same unit as Re about the process for administering a blood #3 stated she would prior to administerin has parameters. LF document the reading completed the check blood pressure is behold the medication doctor) if necessary could find the 6 a.m. readings. LPN #3 stated the checked it, just might on 2/15/17 at 11:46	B a.m., an interview was N #3, a nurse who works on esident #6. When asked followed by staff prior to od pressure medication, LPN d check the blood pressure ag the medication if the order PN #3 stated that she would an on the MAR right after she elow parameters, she would and notify the MD (medical and notify the MD (medical and 2 p.m. blood pressure stated, "The nurse probably th not have written it in."	· 6	RECEIVED  MAR 0 9 2017  VDH/OLG		

with Resident #6. When asked about the process followed by staff prior to administering a blood

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	KO FUR MEDICARE	& MEDICAID SERVICES			<u> </u>	NNR NO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		E CONSTRUCTION		TE SURVEY MPLETED
		495045	B. WING	;			C <b>/15/2017</b>
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				21	125 HILLIARD ROAD		
MANOR	CARE HEALTH SERVI	CES-RICHMOND		R	ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	IX .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (CROSS-REFERENCE)	D BE	(X5) COMPLETION DATE
F 514	stated that he would and put the vital sig if he would do this be stated, "Yes, before this writer where Rep.m. blood pressure When asked where readings were record dose, LPN #4 show signs. When asked #6's clinical record, my personal book." pressure readings so clinical record, LPN documented in the control of the work with the control of the work with the control of the work with the work	n with parameters, LPN #4 d take the blood pressure first ns on the MAR. When asked pefore every dose, LPN #4 every dose." LPN #4 showed esident #6's 9 a.m. and 10 e reading were recorded. Resident #6's blood pressure rded for his 2 p.m. and 6 a.m. red this writer a book of vital I if this was part of Resident LPN #4 stated, "No. This is When asked if his blood should be recorded in the #4 stated, "Yes, it should be clinical record."	F	514			
	Nursing) and ASM # made aware of the a Facility policy titled, documents in part, to	44, the corporate nurse, were					
	complete, readily ac organized. A compl actual experience of	ecessible, and systemically ete clinical record reports the f the individual and contains n to validate patient status					i de la constanti de la consta
	No further information	on was presented prior to exit.			RECEIVED		
		d to treat high blood pressure.			MAR 0 9 2017		
	Institutes of Health.	o obtained from The Hagolian			VDH/OLG		

T0022003/?report=details.

https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0.0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		495045	B. WING	)	02	C <b>/15/2017</b>
	PROVIDER OR SUPPLIER  CARE HEALTH SERV	ICES-RICHMOND		STREET ADDRESS, CITY, STATE, ZIP ( 2125 HILLIARD ROAD RICHMOND, VA 23228	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 125	F 5	514		<u> </u>
		off failed to document Resident orty was notified regarding a 6/17.	į			
	Resident #1 was ad	Imitted to the facility on				

Review of Resident #1's clinical record revealed a nurse's note dated 1/6/17 that documented, "Resident transferred from the Parc unit to room (room number) the third bed today." Further review of nurse's notes and social services notes failed to reveal documentation that the resident's responsible party was notified of the room change.

10/21/16. Resident #1's diagnoses included but were not limited to: major depressive disorder and diabetes. Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/15/17, coded the resident's cognition as being severely

On 2/15/17 at 9:37 a.m., an interview was conducted with OSM (other staff member) #10 (the social services director- employed at the facility for one month) and OSM #8 (the social services coordinator). OSM #10 was asked the facility process regarding room changes. OSM #10 stated the social services staff notifies the resident, the resident's responsible party and the resident residing in the room the other resident is moving into. OSM #10 stated the social services staff also shows the resident the new room introduces the resident to the new roommate and asks for feedback from the residents. At this time, OSM #8 was asked if this process was completed when Resident #1 moved on 1/6/17.

RECEIVED

MAR 0 9 2017

VDH/OLG

impaired.

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR ME	DICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		ATE SURVEY OMPLETED
		495045	B. WING				C 2/15/2017
NAME OF PROVIDER OR S	SUPPLIER	***************************************	1	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
MANORCARE HEALT	H SERV	CES-RICHMOND			5 HILLIARD ROAD HMOND, VA 23228		
PREFIX (EACH D	EFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<b>x</b> .	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
resident's r OSM #8 sta responsible responsible confirmed s On 2/15/17 staff memb (the directo above cond The facility part, "PROO progress no related soci The notes i psychosoci plan interve service inte	ated she esponsil ated she esponsil ated she party at a party when didn' at 2:03 er) #1 (tr of nursern. social services providentify the lates well-bentions, trventions"	ge 126 notified Resident #1 and the ple party of the room change, had to call the resident's the time because the as out of town. OSM #8 to document notification.  p.m., ASM (administrative he administrator) and ASM #2 ing) were made aware of the ervice manual documented in NOTES: Social service ride a review of the medically less that have been provided, he patient's general leing, the effectiveness of care the patient's response to social is and other noteworthy.	F 5	14			
assessmen intervention administrati multiple dat 2017.  Review of F physician's that docume	ts and notes provided to a second to the sec	ailed to document pain on-pharmacological ed to Resident #1 with needed pain medication for cember 2016 and January #1's clinical record revealed a mmary signed on 11/20/16 order for oxycodone (1) 5 mg			MAR 0 9 2017		
(milliorams)	- one ta	hlet by mouth every four			VNHIOLO		Į.

hours as needed.

Resident #1's December 2016 and January 2017

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	CO	TE SURVEY MPLETED
		495045	B. WING		•	C /15/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
MANOR	CADE HEALTH CED\#	ICEC DICUMOND	-	2125 HILLIARD ROAD		
MANOR	CARE HEALTH SERVI	ICES-RICHIMOND		RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 127	· F	514		
	MARs (medication	administration records)				
		nt was administered as				
		on the following dates:				
	12/16/16					
	12/25/16					
	12/26/16	,				
	12/27/16 12/28/16					
	12/29/16					
	12/30/16					
	1/7/17					
	1/8/17					
	1/9/17					
	(including nurses' n MARs) failed to reveassessments and n interventions were p	esident #1's clinical record otes and the back of the eal documentation that pain con-pharmacological provided to Resident #1 with of as needed oxycodone for	i			
	conducted with RN	a.m., an interview was (registered nurse) #9. RN #9				
		rses should do prior to and tion of as needed pain				İ
		stated nurses assess the	•			]
		uding the location and				-
		, provide non-pharmacological	* **			
		he pain medication and then				
	re-assess the reside	ent's pain. RN #9 stated				
		eting this process but he		RECEIVED		j
	•	ed if the nurses had not				ļ
	documented their as	ssessments or al interventions. RN #9 stated	:	MAR 0 9 2017		
	management had e					
		ain assessments and		ADH/OFC		ĺ

interventions and continued to do so.

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X3) PROVIDER OF SUPPLIER  MANORCARE HEALTH SERVICES-RICHMOND  (X4) ID PREFIX (FACH DEPTICIENCY MILST BE PRECEDED BY FLL. TAG  F1-14  CONTINUED FOR A SUMMARY STATEMENT OF DEFICIENCIES (FACH DEPTICIENCY MILST BE PRECEDED BY FLL. TAG  F1-14  CONTINUED FOR page 128  On 2/15/17 at 1:03 p.m., an interview was conducted with LPN (licensed practical nurse) #5 (the nurse responsible of radministering as needed oxycodone to five administering as needed oxycodone to Resident #1 during several of the above dates). LPN #5 stated she assesses the resident to rate the pain and state the location or observes the resident for non-verbal behaviors such as grimacing, guarding and reaching, LPN #5 stated she assesses the resident for non-verbal behaviors such as grimacing, guarding and reaching, LPN #5 stated she assesses the resident she has been offers and interventions. LPN #5 stated she assesses the resident for non-verbal behaviors such as grimacing, guarding and reaching, LPN #5 stated she assesses the resident she has confers on the back of the MAR or in the progress notes in the computer system. LPN #5 stated she assesses the resident #1's pain. LPN #5 stated she sassesses the resident #1's pain. LPN #5 stated she sassesses the resident #1's pain. LPN #5 stated she sassesses the resident #1's pain. LPN #5 stated she sassesses the resident #1's pain LPN #5 stated she sassesses the resident #1's pain LPN #5 stated she sassesses the resident #1's pain. LPN #5 stated she assesses the resident #1's pain. LPN #5 stated she assesses the resident #1's pain. LPN #5 stated she assesses the resident #1's pain LPN #5 stated she assesses the resident #1's pain LPN #5 stated she assesses the resident #1's pain LPN #5 stated she assesses the resident #1's pain LPN #5 stated she assesses the resident #1's pain LPN #5 stated she assesses the resident #1's pain LPN #5 stated she assesses the resident #1's pain LPN #5 stated she assesses the resident #1's pain LPN #5 stated she assesses the	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-RICHMOND  SUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SIZE (EACH DEFICIENCY MIST RE PRECEDED BY FILL. TAG (EACH CORRECTION ACTION SHOULD BE COMPLY TAG (EACH CORRECTION COMPLY ACTION SHOULD BE COMPLY TAG (EACH CORRECTION COMPLY ACTION SHOULD BE COMPLY TAG (EACH CORRECTION COMPLY ACTION SHOULD BE COMPLY TAG (EACH CORRECTION ACTION SHOULD BE COMPLY TAG (EACH CORRECTION COMPLY ACTION SHOULD BE COMPLY TAG (EACH CORRECTION COMPLY TAG (EACH CORRECTION COMPLY TAG (EACH CORRECTION ACTION SHOULD BE COMPLY TAG (EACH CORRECTION ACTION SHOULD BE COMPLY TAG (EACH CORRECTION ACT				1		CONSTRUCTION	(X3) DA	TE SURVEY
MANORCARE HEALTH SERVICES-RICHMOND    2125 HILLIARD ROAD   RICHMOND, W. 2328   RICHMOND, W. 2328   RICHMOND, W. 2328   REACH DEFICIENCY MIST BE PRECEDED BY PULL   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAIG   CAOSS-REFERENCE TO THE APPROPRIATE   DEFICIENCY)    F 514   Continued From page 128   On 2/15/17 at 1:03 p.m., an interview was conducted with LPN (Ilcensed practical nurse) #5 (the nurse responsible for administering as needed oxycodone to Resident #1 during several of the above dates). LPN #5 was asked what nurses should do prior to and after the administration of as needed pain medication. LPN #5 stated she assesses the resident's pain, asks the resident to rate the pain and state the location or observes the resident for non-verbal behaviors such as grimacing, guarding and reaching. LPN #5 stated she also offers non-pharmacological interventions such as positioning. LPN #5 stated after as needed pain medication administration, she re-assesses the resident's pain. LPN #5 was asked where she documents pain assessments and interventions on the back of the MAR or in the progress notes in the computer system. LPN #5 was asked how she assesses the resident's mannerisms for facial grimacing and guarding. LPN #5 stated she also offloads the resident for "backside." At this time, LPN #5 was asked to review Resident #1's December 2016 and January 2017 MARs and nurses' notes and show this surveyor documentation of her pain assessments and interventions on the dates she administered as needed pain medication to the resident. LPN #5 confirmed there was a lack of documentation.    REGULATORY OR ISC.   PROPRIETY   PR			495045	B. WING			02	
FREER TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 514 Continued From page 128  On 2/15/17 at 1:03 p.m., an interview was conducted with LPN (Ilcensed practical nurse) #5 (the nurse responsible for administering as needed oxycodone to Resident #1 during several of the above dates). LPN #5 was asked what nurses should do prior to and after the administration of as needed pain medication. LPN #5 stated she assesses the resident's pain, asks the resident to rate the pain and state the location or observes the resident for non-verbal behaviors such as grimacing, guarding and reaching. LPN #5 stated she also offers non-pharmacological interventions such as positioning. LPN #5 stated after as needed pain medication administration, she re-assesses the resident's pain, LPN #6 was asked where she documents pain assessments and interventions. LPN #6 stated she documents this information on the back of the MAR or in the progress notes in the computer system. LPN #6 was asked how she assesses Resident #1's pain. LPN #5 stated she also offloads the resident's mannerisms for facial grimacing and guarding. LPN #5 stated she also offloads the resident off her 'backside.' At this time, LPN #6 was asked to review  Resident #1's December 2016 and January 2017 MARs and nurses' notes and show this surveyor documentation of her pain assessments and interventions on the dates she administered as needed pain medication to the resident. LPN #5 confirmed there was a lack of documentation.  REGULATORY OR IS THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED			CES-RICHMOND	,	212	5 HILLIARD ROAD		
On 2/15/17 at 1:03 p.m., an interview was conducted with LPN (licenseed practical nurse) #5 (the nurse responsible for administering as needed oxycodone to Resident #1 during several of the above dates). LPN #5 was asked what nurses should do prior to and after the administration of as needed pain medication. LPN #5 stated she assesses the resident's pain, asks the resident to rate the pain and state the location. Jen #1 stated she assesses the resident's pain, asks the resident to rate the pain and state the location. Jen #5 stated she also offers non-pharmacological interventions such as positioning. LPN #5 stated after as needed pain medication administration, she re-assesses the resident's pain. LPN #5 was asked where she documents pain assessments and interventions. LPN #5 stated she documents this information on the back of the MAR or in the progress notes in the computer system. LPN #5 was asked how she assesses Resident #1's pain. LPN #5 stated she assesses Resident #1's pain. LPN #5 stated she assesses the resident's mannerisms for facial grimacing and guarding. LPN #5 stated she also offloads the resident off her "backside." At this time, LPN #5 was asked to review Resident #1's December 2016 and January 2017 MARs and nurses' notes and show this surveyor documentation of her pain assessments and interventions on the dates she administered as needed pain medication to the resident. LPN #5 confirmed there was a lack of documentation.  RECEIVED	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
		On 2/15/17 at 1:03 conducted with LPN (the nurse responsi needed oxycodone of the above dates) nurses should do pladministration of as LPN #5 stated she asks the resident to location or observes behaviors such as greaching. LPN #5 non-pharmacologica positioning. LPN #5 medication administra	p.m., an interview was I (licensed practical nurse) #5 ble for administering as to Resident #1 during several. LPN #5 was asked what rior to and after the needed pain medication. assesses the resident's pain, rate the pain and state the sthe resident for non-verbal primacing, guarding and stated she also offers all interventions such as a stated after as needed pain tration, she re-assesses the N #5 was asked where she residents and interventions. documents this information on R or in the progress notes in m. LPN #5 was asked how lent #1's pain. LPN #5 stated resident's mannerisms for I guarding. LPN #5 stated resident off her "backside." was asked to review mber 2016 and January 2017 notes and show this surveyor or pain assessments and dates she administered as ation to the resident. LPN #5 a lack of documentation.	F. Transport to the state of th	514			
(the director of nursing) were made aware of the above concern.  MAK U 9 ZUI/  WDH/OI C		(the director of nursi				MAR 0 9 2017		

The facility documents titled, "Pain Practice Guide" and "Documentation" failed to document

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/28/2017 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	<del>,</del>		O	MB NO. 0938	-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE SURV COMPLETE	
		495045	B. WING			C <b>02/15/20</b>	17
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STAT	E, ZIP CODE	<u> </u>	<u></u>
MANOR	CARE HEALTH SERVI	CES-RICHMOND		2125 HILLIARD ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPE	BE COMP	(5) LETION ATE
F 514	of pain assessment interventions.  No further informati  (1) Oxycodone is us information was obth https://dailymed.nlm	ge 129 regarding the documentation is and non-pharmacological on was presented prior to exit. sed to treat pain. This ained from the website: n.nih.gov/dailymed/drugInfo.cf f5d9-4296-b8bb-cddbe2dde65		14			
	pharmacological int assessment when a (PRN) medication to document follow up medication administ Resident #17 was a 12/21/16 with a rece with diagnoses that to: heart failure, dial pulmonary disease and atrial fibrillation	dmitted to the facility on ent readmission on 1/13/17 included but were not limited betes, chronic obstructive (COPD), high blood pressure, (rapid and random					
	contractions of the a irregular beats of the The most recent ME assessment, a Medi with an assessment coded the resident a make daily decision requiring extensive a	atria of the heart causing		RECEIVED MAR 0 9 2017 VDH/OLC	)		

living.

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLANOF CORRECTION  AND PLANOF CORRECTION  ASSOCIATE SUBJECT AND PLANOF CORRECTION  NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-RICHMOND  CASH CONTROLL AND PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-RICHMOND  CASH CONTROLL AND PROVIDER OR SUMMARY STATEMENT OF DEFICIENCIES PROCEDURES OF THE PROCEDURE OF MINITED PROCEDURE OF MINISTER OF MINITED PROCEDURE OF MINITED PROCEDURE OF MINITED PROCEDURE OF MINISTER OF MINISTE	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<u> 0938-0391</u>
MANDER OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-RICHMOND  SUMANARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAST SEE PRECEDED BY FILL (FACH DORN), VA. 23228  FREETX (FACH DEFICIENCY MIST SEE PRECEDED BY FILL (FACH CORRECTIVE), COMPASSIVE SEVERE AND CONTROLLED BE COMPASS				1''			
MANORCARE HEALTH SERVICES-RICHMOND  (X4) D SUMMARY STATEMENT OF DEFICIENCIES PREETY TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  Observation was made of LPN (licensed practical nurse) #8 administering medications to Resident #17 on 2/14/17 at 4:07 p.m. LPN #8 administered a Tramadol (used to treat moderate to moderately severe pain (2)) 50 mg (milligrams) one tablet to Resident #17.  Review of the physician order dated, 2/3/17 documented, "Tramadol 50 mg 1 PO (by mouth) Q (every) 6 H (hours) PRN Dx (diagnosis) Pain."  Review of the MAR (medication administration record) for February 2017 documented, "Tramadol 50 mg 1 PO (a H, PRN Dx: Pain." The nurse documented the time of 17:10 (4:10 p.m.) with her initials. The reverse side of the MAR was blank. The MAR also documented, "Pain Score every shift." The score documented for 2/14/17 at 4:00 p.m. was a "0" indicating no pain.  The nurse's notes for 2/14/17 were reviewed. There was no documentation of the administration of the Tramadol.  An interview was conducted with LPN #8 on 2/15/17 at 3:02 p.m., regarding what staff does when a resident complains of pain. LPN #8 stated, "You assess the pain. Check the intensity, the pain level, location of pain." LPN #8 was asked to review the MAR and nurse's notes for 2/14/17. When asked where she documented the assessment, administration of medication and			495045	B. WING	3	0:	
(24) D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 514 Continued From page 130  Observation was made of LPN (licensed practical nurse) #8 administering medications to Resident #17 on 2/14/17 at 4:07 p.m. LPN #8 administered a Tramadol (used to treat moderate to moderately severe pain (2)) 50 mg (milligrams) one tablet to Resident #7.  Review of the physician order dated, 2/3/17 documented, "Tramadol 50 mg 1 PO (by mouth) Q (every) 6 H (hours) PRN Dx (diagnosis) Pain."  Review of the MAR (medication administration record) for February 2017 documented, "Tramadol 50 mg 1 PO (a H, PRN Dx: Pain." The nurse documented the time of 17:10 (4:10 p.m.) with her initials. The reverse side of the MAR was blank. The MAR also documented for 2/14/17 at 4:00 p.m. was a "0" indicating no pain.  The nurse's notes for 2/14/17 were reviewed. There was no documentation of the administration of the Tramadol.  An interview was conducted with LPN #8 on 2/15/17 at 3:02 p.m., regarding what staff does when a resident complains of pain. LPN #8 stated, "You assess the pain. Check the intensity, the pain level, location of pain. LPN #8 saked to review the MAR and nurse's notes for 2/14/17. When asked where she documented the assessment, administration of medication and	NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO		LI TOILOTT
FREETR TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 514  Continued From page 130  Observation was made of LPN (licensed practical nurse) #8 administering medications to Resident #17 on 2/14/17 at 4:07 p.m. LPN #8 administration record) for February 2017 documented, "Tramadol 50 mg 1 PO (by mouth) Q (every) 6 H (hours) PRN Dx: Pain."  Review of the MAR (medication administration record) for February 2017 documented, "Tramadol 50 mg 1 PO (by mouth) Q (every) 6 H (hours) PRN Dx: Pain."  The nurse documented the time of 17:10 (4:10 p.m.) with her initials. The reverse side of the MAR was blank. The MAR also documented for 2/14/17 at 4:00 p.m. was a "0" indicating no pain.  The nurse's notes for 2/14/17 were reviewed. There was no documentation of the administration of the Tramadol.  An interview was conducted with LPN #8 on 2/15/17 at 3:02 p.m., regarding what staff does when a resident complains of pain. LPN #8 stated, "You assess the pain. LPN #8 was asked to review the MAR and nurse's notes for 2/14/17. When asked where she documented the assessment, administration of medication and	MANOR	CARE HEALTH SERV	ICES-RICHMOND		1		
Observation was made of LPN (licensed practical nurse) #8 administering medications to Resident #17 on 2/14/17 at 4:07 p.m. LPN #8 administered a Tramadol (used to treat moderate to moderately severe pain (2)) 50 mg (milligrams) one tablet to Resident #17.  Review of the physician order dated, 2/3/17 documented, "Tramadol 50 mg 1 PO (by mouth) Q (every) 6 H (hours) PRN Dx (diagnosis) Pain."  Review of the MAR (medication administration record) for February 2017 documented, "Tramadol 50 mg 1 PO Q 6 H, PRN Dx: Pain."  The nurse documented the time of 17:10 (4:10 p.m.) with her initials. The reverse side of the MAR was blank. The MAR also documented, "Pain Score every shift." The score documented for 2/14/17 at 4:00 p.m. was a "0" indicating no pain.  The nurse's notes for 2/14/17 were reviewed. There was no documentation of the administration of the Tramadol.  An interview was conducted with LPN #8 on 2/15/17 at 3:02 p.m., regarding what staff does when a resident complains of pain. LPN #8 stated, "You assess the pain. Check the intensity, the pain level, location of pain." LPN #8 was asked to review the MAR and nurse's notes for 2/14/17. When asked where she documented the assessment, administration of medication and	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	EX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION
didn't. He was having back pain on a scale of six out of ten. Before he goes to bed each night, I check on him. He's a very lonely man. He told  WAK U 9 ZUII  VDH/OLC		Observation was murse) #8 administed #17 on 2/14/17 at 4 a Tramadol (used to severe pain (2)) 50 Resident #17.  Review of the physicocumented, "Tramadol for February "Tramadol 50 mg 1 The nurse documented, "Tramadol 50 mg 1 The nurse documented," "Tramadol 50 mg 1 The nurse documented, "Tramadol 50 mg 1 The nurse documented," "Tramadol 50 mg 1 The nurse documented, "Tramadol 50 mg 1 The nurse documented," "Tramadol 50 mg 1 The nurse documented, "Tramadol 50 mg 1 The nurse documented at 4:00 pain.  The nurse's notes for There was no documented at 3:02 p.m. when a resident constated, "You assess the pain level, location asked to review the 2/14/17. When asked assessment, adminfollow up on the effection." He was having a severe pain level, adminfollow up on the effection.	arade of LPN (licensed practical being medications to Resident 1:07 p.m. LPN #8 administered to treat moderate to moderately mg (milligrams) one tablet to milligrams) one tablet to milligrams) one tablet to milligrams) one tablet to milligrams) one tablet to milligrams one tablet to milligrams one tablet to milligrams one tablet to milligrams one tablet to milligrams one tablet to milligrams one tablet to milligrams one tablet to milligrams one tablet to milligrams one table to milligrams one table to milligrams one table to milligrams one table table milligrams one table table milligrams one table table milligrams one table table milligrams one table table milligrams one table table milligrams one table table milligrams one table table milligrams one tab	The constitution of the contract of the contra	RECEIVED  MAR 0 9 2017		

me then that he was more comfortable after the pain medication." When asked if she had tried

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO. 0938-0391</u>		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495045	B. WING	i		C <b>02/15/2017</b>		
NAME OF	PROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				2	2125 HILLIARD ROAD			
WANURU	CARE HEALTH SERV	CES-RICHMOND		F	RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 514	Continued From pa	ge 131	F 5	514	, 1			
	any non-pharmacologic interventions prior to				•			
	giving the pain medication, LPN #8 stated he had							
	just been repositioned by the aide and was still in		-					
	pain." When asked where she documented		*					
	everything she did for this resident, LPN #8							
	stated, "I didn't."							
	The facility policy, "Medication Administration: Medication Pass" documented in part, "Suggested Documentation: Unusual observations or complaints and subsequent interventions including communications with physician."  The administrator was made aware of the above concern on 2/15/17 at 3:28 p.m.							
	No further information was provided prior to exit.							
		ary of Medical Terms for the r 5th edition, Rothenberg and						
	Chapman; page 55.							
-	(2) This information following website:	was obtained from the						
		.nih.gov/dailymed/drugInfo.cf						
	m?setid=246a45d0-0953-4f4f-8175-dab3bafac2d							
	b.							
	4. The facility staff t	iled another resident's						
		Resident #5's clinical record.						
	Resident #5 was most recently readmitted to the facility on 8/11/15 with the diagnoses of but not limited to a brain injury, high blood pressure, stroke, obstructive pulmonary disease, neurogenic bladder, dysphagia, and a sacral ulcer. The most recent MDS (Minimum Data Set)			C	RECEIVED	,		
					MAR 0 9 2017			
				•	VDH/OLG			

was a quarterly assessment with an ARD (Assessment Reference Date) of 12/16/16. The

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICARD SERVICES					<u> </u>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495045	B. WING_	****	C <b>02/15/2017</b>		
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-RICHMOND				STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI	LD BE COMPLETION		
F 514	ability to make daily required total care to bathing; extensive a eating; and was condowel and as havin.  A review of the clining results for a CMP (complete 1/25/17. Further retests were actually filed in Resident #5'.  On 2/15/17 at 2:50 conducted with LPN the unit manager. Stilling is done on the sometimes on the 3 not speak for who in A review of the facilinot address the accomplete of Nursing Member #2) were manager. Store of Nursing Member #2 were manager. Store of the survey of th	d as being severely impaired in y life decisions. The resident for transfers, hygiene, and assistance for dressing and ded as being incontinent of a catheter for bladder.  ical record revealed laboratory complete metabolic panel (1)) e blood count (2)) dated eview revealed these laboratory for another resident but were its clinical record.  p.m., an interview was N (licensed practical nurse) #1, She stated that most of the e 11pm to 7am shift, and 3pm to 11pm shift. She could may have misfiled the labs.  lity policy "Filing system" did curacy of the filing.  p.m., the administrator ff Member #1) and the DON g - Administrative Staff made aware of the above er information was provided by ey.	Verification 1	4			
	(1) A comprehensive metabolic panel is a group of chemical tests performed on the blood serum (the part of blood that doesn't contain cells). These tests include total cholesterol, total protein, and various electrolytes. Electrolytes in the body include sodium, potassium, chlorine, and many others. The rest of the tests measure chemicals			RECEIVED  MAR 0 9 2017  VDH/OLC			

that reflect liver and kidney function. This test

PRINTED: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	KS FOR MEDICARE	& MEDICAID SERVICES			O	<u>WR NO</u>	). 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED  C 02/15/2017			
		495045	B. WING						
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	***************************************			
MANORO	ARE HEALTH SERV	ICES-RICHMOND		2125 HILLIARD ROAD					
MANOROACE MEALTH DERVICES-MONIMORES			RICHMOND, VA 23228						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION			
F 514	Continued From pa	ge 133	F 5	514					
	helps provide information about your body's			- ' '			:		
		es your doctor information							
		neys and liver are working,	•						
		evaluate blood sugar,							
		lcium levels, among other	:						
	things. This information was obtained from the website: <a href="http://www.nlm.nih.gov/medlineplus/ency/article/">http://www.nlm.nih.gov/medlineplus/ency/article/</a>								
	003468.htm>								
	(2) According to Mo	sby's Medical Dictionary, sixth	ŧ						
		ouis, MO: Mosby, Inc. Page							
		ete blood count) is a blood test	1						
		he number of red and white	:						
	blood cells per cubic millimeter of blood; and is one of the most valuable screening and								
	diagnostic techniqu								
	g.,								
							***************************************		
		•							
REGEIVED  MAR 0 9 2017									
VDH/CLG									