PRINTED: 05/21/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAL SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ C 495045 B. WING 05/13/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD MANORCARE HEALTH SERVICES-RICHMOND RICHMOND, VA 23228 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY)** The statements made on this F 000 INITIAL COMMENTS F 000 plan of correction are not an admission to and do not An unannounced Medicare/Medicaid abbreviated constitute an agreement with standard survey was conducted 5/12/15 through the alleged deficiencies cited 5/13/15. One complaint was investigated during herein. the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long To remain in compliance with Term Care requirements. all federal and state regulations. The census in this 194 certified bed facility was the center has taken or will take 147 at the time of the survey. The survey sample the actions set forth in the consisted of 4 current Residents reviews following plan of correction. (Residents #1 through #4). The following plan of correction F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) F 225 constitutes the center's INVESTIGATE/REPORT SS=D allegation of compliance. All ALLEGATIONS/INDIVIDUALS alleged deficiencies cited have been or will be corrected by the The facility must not employ individuals who have date or dates indicated. been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; F225 06/05/15 and report any knowledge it has of actions by a court of law against an employee, which would It is the intended practice of this facility to indicate unfitness for service as a nurse aide or follow our Patient Protection Practice other facility staff to the State nurse aide registry Guide process. or licensing authorities. Criteria 1 Resident #2's allegation was investigated The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse. and reported to the State Agencies as including injuries of unknown source and required by regulation on 5/14/2015 by the misappropriation of resident property are reported Administrator. immediately to the administrator of the facility and

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

The facility must have evidence that all alleged

to other officials in accordance with State law

State survey and certification agency).

through established procedures (including to the

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: DU4S11

Facility ID: VA0241

Criteria 2

since March 1, 2015 was completed by the Administrator/designee to evaluate that

An audit of investigations and concerns

investigations were completed.

TITLE

If continuation sheet Page 1 of 26

(X6) DATE

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

PRINTED: 05/21/2015 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495045	B. WING				C 42/204E
	PROVIDER OR SUPPLIE	ER		S' 2'	TREET ADDRESS, CITY, STATE, ZIP CODE 1125 HILLIARD ROAD RICHMOND, VA 23228	Uər	13/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	revent further poinvestigation is in The results of all to the administrat representative an with State law (incertification agenincident, and if the appropriate corresponding to the facility staff in review, clinical reacomplaint invested facility staff fa allegation of abustour residents in the facility staff, his management of the state agence to the state agence. The findings included the state agence of the facility failed to the state agence. The findings included the state agence of the findings included the findings inclu	investigations must be reported tor or his designated and to other officials in accordance acluding to the State survey and accy) within 5 working days of the alleged violation is verified active action must be taken. IENT is not met as evidenced and the course of stigation, it was determined that alled to immediately report an ase to the state agency for one of the survey sample, Resident #2. Deer of Resident #2 informed the nother told him she had been hit. to report this allegation of abuse cy.		225	Staff reeducated on the Prevent Policy procedure and reporting timely. Criteria 4 The Administrator/designee will audi investigations weekly x4 weeks and monthly x2 months and report to QA committee for review and recommendations. Criteria 5 The facilities alleged date of complia June 5, 2015.	it A ance is	
	The most recent	MDS (minimum data set)		The state of the s	.,orc		

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

Event ID: DU4S11

Facility ID: VA0241

If continuation sheet Page 2 of 26

PRINTED: 05/21/2015 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			ATE SURVEY OMPLETED
	495045	B. WING			C 5/13/2015
PROVIDER OR SUPPLIEF	₹	1	STREET ADDRESS, CITY, STATE, ZIP C		3/13/2013
CARE HEALTH SER	VICES-RICHMOND		2125 HILLIARD ROAD RICHMOND, VA 23228		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
Continued From p	age 2	F 2			
assessment references ident as usually usually making he was coded with a status) as an 11, if moderately impair decisions. In Secresident was code assistance for moderately impair decisions. In Secresident was code assistance for moderately impair decisions. In Secresident was code assistance for moderately impair decisions.	ence date of 3/13/15, coded the y understanding others and rself understood. The resident BIMS (brief interview for mental ndicating that the resident was ed to make cognitive daily tion G - Functional Status, the das requiring extensive st of her activities of daily living. The conference with the 1/12/14 at 4:15 p.m. a request of the facility reported incidents				
FRIs that had bee agency. There was agency. There was agency. There was a review of the clin approximately 8:3 the nurse's notes, Type: Patient Safe facility stating that hit. Upon entering resident was sittin with no distress no stated that she did and would like to I any physical abus nursing assistant) assessment, left ubruising, redness prominence area. appears to be hear	n submitted to the state as none for Resident #2. nical record on 5/13/15 at 0 a.m., revealed documented in "4/25/15 17:39 (5:39 p.m.) ety. Resident son called to his mother stated that she was the unit @ (at) 5:30 p.m. g in wheelchair in hall calm and oted. Ask (sic) if she was ok I not know where her room was ay down. Denies any pain, and e. Assist by CNA (certified and charge nursing in full body apper arm quarter side (sic) old on back in mid back boney Bandage on left lower leg that ling. No new bruising or				
	CARE HEALTH SERVE SUMMARY STATE (EACH DEFICIENCE REGULATORY OR REGULATORY OR REGULATORY OR Assessment, a quassessment refere resident as usually usually making he was coded with a status) as an 11, in moderately impair decisions. In Sector resident was code assistance for moderately impair decisions. In Sector resident was code assistance for moderately impair decisions. In Sector resident was code assistance for moderately impair decisions. In Sector resident was code assistance for moderately impair decisions. In Sector resident was code assistance for moderately impair decisions. In Sector resident was code assistance for moderately impair decisions. The administrator of FRIs that had bee agency. There was a review of the clin approximately 8:30 the nurse's notes, Type: Patient Safe facility stating that hit. Upon entering resident was sitting with no distress no stated that she did and would like to lany physical abusing assistant) assessment, left ubruising, redness appears to be hear alteration of skin of the prominence area.	A95045 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 2 assessment, a quarterly assessment, with an assessment reference date of 3/13/15, coded the resident as usually understanding others and usually making herself understood. The resident was coded with a BIMS (brief interview for mental status) as an 11, indicating that the resident was moderately impaired to make cognitive daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance for most of her activities of daily living. During the entrance conference with the administrator on 5/12/14 at 4:15 p.m. a request was made for all of the facility reported incidents (FRIs) that had been submitted and sent to the	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 2 assessment, a quarterly assessment, with an assessment reference date of 3/13/15, coded the resident as usually understanding others and usually making herself understood. The resident was coded with a BIMS (brief interview for mental status) as an 11, indicating that the resident was moderately impaired to make cognitive daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance for most of her activities of daily living. During the entrance conference with the administrator on 5/12/14 at 4:15 p.m. a request was made for all of the facility reported incidents (FRIs) that had been submitted and sent to the state agency. The administrator brought the copies of the five FRIs that had been submitted to the state agency. There was none for Resident #2. A review of the clinical record on 5/13/15 at approximately 8:30 a.m., revealed documented in the nurse's notes, "4/25/15 17:39 (5:39 p.m.) Type: Patient Safety. Resident son called to facility stating that his mother stated that she was hit. Upon entering the unit @ (at) 5:30 p.m. resident was sitting in wheelchair in hall calm and with no distress noted. Ask (sic) if she was ok stated that she did not know where her room was and would like to lay down. Denies any pain, and any physical abuse. Assist by CNA (certified nursing assistant) and charge nursing in full body assessment, left upper arm quarter side (sic) old bruising, redness on back in mid back boney prominence area. Bandage on left lower leg that appears to be healing. No new bruising or alteration of skin observed. (Name of son) called	PROVIDER OR SUPPLIER CARE HEALTH SERVICES-RICHMOND SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEIED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 assessment, a quarterly assessment, with an assessment reference date of 3/13/15, coded the resident was usually understanding others and usually making herself understood. The resident was coded with a BIMS (brief interview for mental status) as an 11, indicating that the resident was moderately impaired to make cognitive daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance for most of her activities of daily living. During the entrance conference with the administrator on 5/12/14 at 4:15 p.m. a request was made for all of the facility reported incidents (FRIs) that had been submitted and sent to the state agency. There was none for Resident #2. A review of the clinical record on 5/13/15 at approximately 8:30 a.m., revealed documented in the nurse's notes, "#12/5/15 17:39 (5:39 p.m.) Type: Patient Safety, Resident son called to facility stating that his mother stated that she was hit. Upon entering the unit @ (at) 5:30 p.m. Type: Patient Safety, Resident son called to facility stating that his mother stated that she was hit. Upon entering the unit @ (at) 5:30 p.m. Type: Patient Safety, Resident son called to facility stating that his mother stated that she was hit. Upon entering the unit @ (at) 5:30 p.m. Type: Patient Safety, Resident son called to facility stating that his mother stated that she was hit. Upon entering the unit @ (at) 5:30 p.m. Type: Patient Safety, Resident son called to facility stating that his mother stated that she was hit. Upon entering the unit @ (at) 6:30 p.m. Type: Patient Safety, Resident son called to facility stating that his mother stated that she was hit. Upon entering the unit @ (at) 6:30 p.m. Type: Patient Safety, Resident son called to facility stating that his mother stated that she was hit. Upon entering the unit @ (at) 6:30 p	DECORRECTION A95045 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 2 assessment, a quarterly assessment, with an assessment reference date of 3/13/15, coded the resident as usually understanding others and usually making herself understood. The resident was moderately impaired to make cognitive daily decisions. In Section 6 - Functional Status, the resident was coded with a BIMS (brief interview for mental status) as an 11, indicating that the resident was moderately impaired to make cognitive daily decisions. In Section 6 - Functional Status, the resident was coded as requiring extensive assistance for most of her activities of daily living. During the entrance conference with the administrator on 5/12/14 at 4:15 p.m. a request was made for all of the facility reported incidents (FRIs) that had been submitted and sent to the state agency. The administrator brought the copies of the five FRIs that had been submitted to the state agency. There was none for Resident #2. A review of the clinical record on 5/13/15 at approximately 8:30 a.m., revealed documented in the nurse's notes, "4/25/5 17:39 (5:39 p.m.) Type: Patient Safety, Resident son called to facility stating that his mother stated that she was hit. Upon entering the unit @ (at) 5:30 p.m. Type: Patient Safety, Resident son called to facility stating that his mother stated that she was hit with no distress noted. Ask (sic) if she was ok stated that she did not know where her room was and would like to lay down. Denies any pain, and any physical abuse. Assist by CNA (certified nursing assistant) and charge nursing in full body assessment, left upper arm quarter side (sic) old bruising, redness on back in mid back boney prominence area. Bandage on left lower leg that appears to be healing. No new bruising or sold left and the proper side of the proper side of the proper side

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

Event ID: DU4S11

Facility ID: VA0241

If continuation sheet Page 3 of 26

RECEIVED

MAY 28 2015

PRINTED: 05/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	495045	B. WING		05	C 05/13/2015	
NAME OF PROVIDER OR SUPPL		212	REET ADDRESS, CITY, STATE, ZIP CODE 25 HILLIARD ROAD CHMOND, VA 23228		713/2013	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
changes. MD (order for u/a c/s sensitivities). A resting."	n page 3 charting x (for) 72 (hours) for any medical doctor) notified, new (urinalysis, urine culture with this noted resident is in bed	F 225				
5/13/15 at 9:56 family member that they had be make sure the r	a.m., regarding what she does if a tells her that their mother stated een hit. CNA#7 stated, "First I esident is safe. I tell my charge isor. We need to protect the				•	
practical nurse) regarding the prepared in the	s conducted with LPN (licensed #3 on 5/13/15 at 10:04 a.m. rocess he follows if a family m that their mother stated that she PN #3 stated, "First I check the the current caregiver and see if hing. I tell my supervisor and start n." LPN #3 was asked if a resident n changes the process to follow egation. LPN #3 stated, "No, it is abuse and has to be investigated					
nurse) #2, the u a.m., regarding family member stated she was resident's safety supervisor or th	s conducted with RN (registered nit manager, on 5/13/15 at 10:05 what process she follows if a informed staff their mother has hit. RN #2 stated, "I ensure the offirst and foremost. I call my e administrator right away. We gation immediately."					
staff member (A	s conducted with administrative (SM) #3, the assistant director of (1/15 at 10:10 a.m., regarding the					

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

Event ID: DU4S11

Facility ID: VA0241

If continuation sheet Page 4 of 26

RECEIVED

MAY 28 2015

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

We question staff and proceed with the

may be involved until the investigation is

copy of the FRI was requested from the administrator regarding the allegation of abuse

An interview was conducted with the ASM #1.

documented in the clinical record.

investigation. We suspend any staff member that

complete." When asked if the allegation is from a resident with a lower BIMS score, does that change anything, ASM #1 stated, "No, we will have to rely on staff statements and possibly roommate statement." When asked if she would report something like this, the statement from the family member, ASM #1 stated," Probably would look at it and then determine if it is reportable. Typically any allegation of abuse is reported." A

Event ID: DU4S11

Facility ID: VA0241

If continuation sheet Page 5 of 26

RECEIVED

MAY 28 2015

		AND HUM SERVICES			FORM	D: 05/21/2015 M APPROVED		
STATEMENT		& MEDIC SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DA	D. 0938-0391 TE SURVEY MPLETED		
		495045	B. WING		0;	C 5/ 13/2015		
NAME OF F	ATEMENT OF DEFICIENCIES DE LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495045 HAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-RICHMOND (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		·	STREET ADDRESS, CITY, STATE, ZIP CODE				
MANORO	CARE HEALTH SERVI	CES-RICHMOND	2125 HILLIARD ROAD RICHMOND, VA 23228					
PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 225	Continued From pa	ge 5	F 22	5				
	nursing on 5/13/15 that the facility did ragency. ASM #1 stamanager on duty (Noresident. A concerninternal form. The on the resident. The assessed the skin. her story. We called and called her in to the investigation. So and the resident chatted any concern. When asked if this abuse, ASM #1 stated any concern. When asked if this abuse, ASM #1 stated abuse and neglect. allegation of abuse ASM #1 stated, "No staff, residents or volume to your attentiat not considered #1 stated, "He wand mother. He was conurse's note dated, reviewed with ASM nurse's first sentence conversation with the informed this surverse."	at 11:00 a.m. ASM #1 stated not file a FRI with the state ated, "I spoke with the MOD) and she checked on the form was created, it's an MOD and the nurse checked by got her statement, and the nurse manager on duty assess the resident and start the interviewed the resident anged her story and had not as for abuse or mistreatment." was not an allegation of the it was all the it was allegation of the it was allegation of the it was all the it was allegation of the it was allegation of the it was allegation of the it was all the it was allegation of the it was allegation of the it was all the it was all the it was all the i						

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

An interview was conducted with RN #3 on 5/13/15 at 1:26 p.m. RN #3 was asked to read her nurse's note dated 4/26/15 at 5:39 p.m. Once she had read the note RN #3 was asked to

RN #3.

Event ID: DU4S11

Facility ID: VA0241

If continuation sheet Page 6 of 26

RECEIVED

MAY 28 2015

PRINTED: 05/21/2015 DEPARTMENT OF HEALTH AND HUM SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC J SERVICES € OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495045 B. WING 05/13/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD MANORCARE HEALTH SERVICES-RICHMOND RICHMOND, VA 23228 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 225 Continued From page 6 F 225 describe what happened that day. She stated, "I got a call from the administrator to come to the building and start an investigation because a family member had stated that the resident told him that she had been hit. The family member called the facility as he was concerned about his mother. I came to the facility and went directly to see (Resident #2). She was in the hallway in her wheelchair. She was calm, did not appear to be in any distress. I asked her if she was okay and if anyone had hurt her. She stated that she was 'fine' and just wanted to find her room to go to bed. The aides helped me put her to bed and we did a full skin assessment of her. I called the son and told him what we had done and he was pleased with what we had done." When asked exactly what the son stated to her, RN #3 stated, "He told me he called because he was concerned about his mother when she said someone had hit her." When asked the process in the facility for reporting any allegation of abuse, RN #3 stated. "Whenever there is an allegation of abuse, we go to the administrator as she is the abuse prevention coordinator." The facility policy, "Patient Protection Practice Guide" documented, "Report/Respond: The center must ensure that all alleged violations involving mistreatment, neglect or abuse. including injuries of unknown origin and misappropriation of resident property are reported immediately to the administrator of the facility and

other officials in accordance with state law through established procedures (including to the

ASM #1 and ASM #2 were made aware of these

state survey and certification agency)."

findings on 5/13/15 at 3:26 p.m.

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

PRINTED: 05/21/2015 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495045	B. WING _			C / 13/2015	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	CES-RICHMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 226	A83.13(c) DEVELO ABUSE/NEGLECT The facility must depolicies and proced mistreatment, negle and misappropriation This REQUIREMED by: Based on staff interested and clinical record the facility staff failed procedures to repostate agency for on survey sample, Resident agency. On 4 reported to facility staff all immediately report state agency. On 4 reported to facility staff all immediately report state agency. On 4 reported to facility staff all immediately report state agency. On 4 reported to facility staff all immediately staff all immediately staff all immediately report state agency. On 4 reported to facility staff all immediately report state agency. The findings included abuse to the state at the findings included to immediate abuse to the state at the findings included to immediate abuse to the state at the findings included to immediate abuse to the state at the findings included	ion was provided prior to exit. P/IMPLMENT , ETC POLICIES evelop and implement written lures that prohibit ect, and abuse of residents on of resident property. NT is not met as evidenced erview, facility document review review, it was determined that ed to implement policies and rt an allegation of abuse to the e of four residents in the sident #2. ed to implement their policy to an allegation of abuse to the staff that his mother (Resident been hit. The facility staff ly report this allegation of agency.	F 22		igated as 5 by the erns i by the that icy and dit	06/05/15	
	failure, pneumonia						

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

Event ID: DU4S11

Facility ID: VA0241

If continuation sheet Page 8 of 26

RECEIVED

MAY 28 2015

PRINTED: 05/21/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495045 B. WING 05/13/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD MANORCARE HEALTH SERVICES-RICHMOND RICHMOND, VA 23228 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 226 Continued From page 8 F 226 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/13/15, coded the resident as usually understanding others and usually making herself understood. The resident was coded with a BIMS (brief interview for mental status) as an 11, indicating that the resident was moderately impaired to make cognitive daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance for most of her activities of daily living. During the entrance conference with the administrator on 5/12/14 at 4:15 p.m. a request was made for all of the facility reported incidents (FRIs) that had been submitted and sent to the state agency. The administrator brought the copies of the five FRIs that had been submitted to the state agency. There was none for Resident #2. A review of the clinical record on 5/13/15 at approximately 8:30 a.m., revealed documented in the nurse's notes, "4/25/15 17:39 (5:39 p.m.) Type: Patient Safety. Resident son called to facility stating that his mother stated that she was hit. Upon entering the unit @ (at) 5:30 p.m. resident was sitting in wheelchair in hall calm and with no distress noted. Ask (sic) if she was ok stated that she did not know where her room was and would like to lay down. Denies any pain, and RECEIVED

any physical abuse. Assist by CNA (certified nursing assistant) and charge nursing in full body assessment, left upper arm guarter side (sic) old

bruising, redness on back in mid back boney prominence area. Bandage on left lower leg that

appears to be healing. No new bruising or alteration of skin observed. (Name of son) called

MAY 28 2015

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES					FORM	# APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	F		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495045	B. WING	i		05	C 5 /13/2015
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	ICES-RICHMOND		2.	TREET ADDRESS, CITY, STATE, ZIP CODE 125 HILLIARD ROAD 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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	satisfied. Alert cha changes. MD (med order for u/a c/s (ur sensitivities). At this resting." An interview was constructed by the street of t	perform (sic), state he was rting x (for) 72 (hours) for any dical doctor) notified, new inalysis, urine culture with is noted resident is in bed onducted with CNA #7 on a, regarding what she does if a sher that their mother stated hit. CNA #7 stated, "First I dent is safe. I tell my charge we he we he with LPN (licensed on 5/13/15 at 10:04 a.m. as he follows if a family nat their mother stated that she was stated, "First I check the ecurrent caregiver and see if a tell my supervisor and start. PN #3 was asked if a resident hanges the process to follow tion. LPN #3 stated, "No, it is use and has to be investigated onducted with RN (registered manager, on 5/13/15 at 10:05 at process she follows if a rmed staff their mother has RN #2 stated, "I ensure the st and foremost. I call my dministrator right away. We	F	226			
		onducted with administrative I) #3, the assistant director of					

PRINTED: 05/21/2015

		AND HUM SERVICES			FORI	M APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	D. 0938-0391 ATE SURVEY PMPLETED
		495045	B. WING_		0:	C 5/13/2015
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-RICHMOND		STREET ADDRESS, CITY, STATE, 2 2125 HILLIARD ROAD RICHMOND, VA 23228	!IP CODE	
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 226	facility procedure to member informs the (resident) stated the stated, "First we may be find out which is the resident. I call and the administrate when asked if the score, does that chinvestigation, ASM complete an investia family member in statement about be allegation of abuse. An interview was conditionally member in statement about be allegation of abuse. An interview was conditionally member a family member in statement (resident) statement (resident) statement (resident) statement (resident) statement (resident) statement investigation. We sure winvestigation. We sure winvestigation. We sure a resident with a lower change anything, A have to rely on staff roommate statement report something like family member, AS look at it and then controlly any allegations of the FRI was copy of the FRI was statement.	at 10:10 a.m., regarding the be followed when a family e staff that the parent ey had been hit. ASM #3 ake sure the resident is safe. Staff member was caring for the DON (director of nursing) for and begin an investigation. The resident has a lower BIMS ange anything in the stated, "No, we still must igation." ASM #3 was asked if forming staff of a resident sing hit is considered an and ASM #3 stated, "Absolutely." Inducted with the staff that the lated they had been hit. ASM immediately start an ensure the resident's safety. In a proceed with the suspend any staff member that will the investigation is from a late BIMS score, does that SM #1 stated, "No, we will statements and possibly int." When asked if she would see this, the statement from the M #1 stated," Probably would determine if it is reportable. It is requested from the ding the allegation of abuse	F 22		ECEIVED MAY 2 8 2015 VDH/OLC	

	DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICA SERVICES					FORM	D: 05/21/2015 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY
		495045	B. WING			05	C 5/13/2015
NAME OF F	PROVIDER OR SUPPLIER		··· I	1	STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	ICES-RICHMOND		1	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 PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 226	Continued From pa	age 11	F:	226			
		onducted with the ASM #1,					
:		ASM #3, assistant director of					
		at 11:00 a.m. ASM #1 stated not file a FRI with the state					
:		ated, "I spoke with the					
	manager on duty (N	MOD) and she checked on the					
;		n form was created, it's an					:
	t control of the cont	MOD and the nurse checked					
		ey got her statement, The resident had changed					
		d the nurse manager on duty			±		
		assess the resident and start					
!	the investigation. S	She interviewed the resident					
ļ		nanged her story and had not	tomphysics (
		is for abuse or mistreatment."					•
		was not an allegation of ited, "The resident changed	-				
**************************************		ned, The resident changed ot feel it was an allegation of					
**************************************		ed it as a concern to rule out					
	abuse and neglect.	. When asked if a concern or					
		only come from a resident,					
ļ		o, it can come from the family,					
!		risitors." When asked then if on of someone being hit					
į		ention by a family member was					
* · · · · · · · · · · · · · · · · · · ·		I an allegation of abuse, ASM					
	#1 stated, "He want	ted someone to check on his					
		oncerned about her." The					
		, 4/25/15 at 5:39 p.m. was					
		#1. ASM #1 stated, "The ce is incorrect according to my					
		he nurse manager." ASM #3					
andre :		eyor that the nurse (RN #3) was					
	in the building. An ii	interview was requested with					
!	RN #3.	;					

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

An interview was conducted with RN #3 on 5/13/15 at 1:26 p.m. RN #3 was asked to read her nurse's note dated 4/26/15 at 5:39 p.m. Once

Event ID: DU4S11

Facility ID: VA0241

If continuation sheet Page 12 of 26

RECEIVED

MAY 28 2015

		AND HUMAN SERVICES & MEDICAL SERVICES			C		FORM	05/21/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DAT COM	E SURVEY IPLETED
		495045	B. WING					C 1 3/2015
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-RICHMOND		212	EET ADDRESS, CITY, STATE, ZIP CO 5 HILLIARD ROAD :HMOND, VA 23228	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD I	BE	(X5) COMPLETION DATE
F 226	she had read the not describe what happ got a call from the abuilding and start at family member had him that she had be called the facility as mother. I came to the see (Resident #2). Wheelchair. She wain any distress. I as anyone had hurt he 'fine' and just wanter bed. The aides held did a full skin assess and told him what we pleased with what we exactly what the son "He told me he calle about his mother wher." When asked to reporting any allegar "Whenever there is to the administrator prevention coordinate." The facility policy, "Guide" documented center must ensure involving mistreatm including injuries of misappropriation of immediately to the action of the stablished state survey and center survey survey and center survey s	the RN #3 was asked to ened that day. She stated, "I administrator to come to the in investigation because a stated that the resident told then hit. The family member he was concerned about his ne facility and went directly to She was in the hallway in her as calm, did not appear to be sked her if she was okay and if it. She stated that she was not to find her room to go to ped me put her to bed and we sment of her. I called the son we had done and he was we had done." When asked in stated to her, RN #3 stated, and because he was concerned then she said someone had hit he process in the facility for the process in the facility for the process in the facility for the process in the abuse that all alleged violations ent, neglect or abuse, unknown origin and resident property are reported administrator of the facility and cordance with state law procedures (including to the	F	226				

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

findings on 5/13/15 at 3:26 p.m.

Event ID: DU4S11

Facility ID: VA0241

If continuation sheet Page 13 of 26

RECEIVED

MAY 28 2015

		AND HUMAN SERVICES & MEDICAL SERVICES		C	PRINTED: FORM A OMB NO.	PPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495045	B. WING		05/1	3/2015
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-RICHMOND	2	TREET ADDRESS, CITY, STATE, ZIP CODE 125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	Continued From pa	age 13	F 226			
	No further informat 483.25(h) FREE OI HAZARDS/SUPER		F 323			
	environment remail as is possible; and	nsure that the resident ns as free of accident hazards each resident receives on and assistance devices to				
	by: Based on observar document review, of course of a complated determined that the resident safety while	NT is not met as evidenced tion, staff interview, facility clinical record review and in the int investigation, it was a facility staff failed to ensure the changing bed linens to the of four residents in the sident #1.		Past noncompliance: no plan o correction required.	of	
·	rolled Resident #1 draw sheet to chan took her hands off sheets and Resider of the bed onto the	rtified nursing assistant) #8 onto her right side using a ge the bed linens. CNA #8 the resident, turned to grab the nt #1 fell off the opposite side floor. Resident #1 sustained fracture of the right leg as			EIVED	

* Tibia is the inner and larger bone of the lower leg also known as the shin bone. (1)
** Fibula is the long thinner outer bone of the lower leg also known as the calf bone. (1)

		I AND HUMAN SERVICES				RINTED: 05/21/2015 FORM APPROVED MB NO. 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495045	B. WING	>		05/13/2015
	PROVIDER OR SUPPLIER CARE HEALTH SERVI		-	2	TREET ADDRESS, CITY, STATE, ZIP CODE 125 HILLIARD ROAD RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 323	Continued From pa	ige 14	F	323		:
		the bed during a linen change bones in her right leg.		W		:
	The findings include	e :		1		
	9/20/09 with a read diagnoses that incluanemia, dementia, swallowing) ^, apha	dmitted to the facility on finission on 9/17/13 with uded but were not limited to: dysphagia (difficulty asia (difficulty speaking) ^, neumonia and recent fractures ila.	***************************************			10 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -
	assessment, a qual assessment referer resident as sometimes making #1 was coded as be object identification to follow objects. It was unable to answ (brief interview for rinterview coded the long term memory coded as being seviced she never/rarely massection G - Function	IDS (minimum data set) interly assessment, with an ince date of 3/26/15, coded the mes understanding others and herself understood. Resident eing highly visually impaired, in question, but eyes appear was coded that the resident wer the questions on the BIMS mental status). The staff e resident with both short and difficulties. The resident was verely impaired, indicating that ade decisions of daily life. In onal Status, Resident #1 was		THE PARTY OF THE P		
	coded as being total	ally dependent upon two staffing to and from a lying position,	The state of the s		RECE	IVED
		and positioning body while in 400 - Functional Limitation in			MAY 28	2015
	interfered with daily at risk of injury, the	ode for limitation that / functions or placed resident resident was coded as having			VDH/0	OLC

side of her upper extremities. Resident #1 was

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES						FOR	VI APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTII	PLE CONSTRUCTION	(X3) DA	0. 0938-0391 TE SURVEY
AND PLAN C)F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	OMIC	G	co	MPLETED
		495045	B. WING	}		0:	C 5/ 13/2015
NAME OF I	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 DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Continued From pa coded in Section K weighing 175 poun	- Swallowing and Nutrition as	F;	32:	3		
	at 5:45 p.m. and 6: in bed with the hea feeding was infusir was awake but nor resident's back was The resident's knee slightly angled to the had contractures (a permanent contract of muscle fibers) (1) She was moving he her covers. Reside size bed. Resident	nade of Resident #1 on 5/12/15 15 p.m. The resident was lying d of the bed elevated. A tube ig at this time. The resident n-communicative. The s on the surface of the bed. es were up near her chest he left side of the resident. She han abnormal, usually tion of a muscle due to atrophy 1) of her left arm and hand. Her right hand over the edges of hit #1 was in a regular standard #1 was again observed on hit in a larger size bed. It to be sleeping.					
	approximately 10:3 dated 5/7/15 at 9:4 (patient) fell during completed, primary practitioner). New to hospital for evaluabout fall. Son ok (name of hospital)	was reviewed on 5/13/14 at 0 a.m. The nurse's notes 1 a.m., documented, "Pt patient care. Assessment rurse notified NP (nurse orders given to send resident pation. Writer spoke with son for resident to (be sent to) ER (emergency room). Son work now to go to the ER to			RE	CEIV	- D
	The hospital record	Is were reviewed. The			MA	7 2 8 20	
	emergency room p 5/7/15 at 11:19 a.m with past medical h	hysician documented on ., "92 y. o. (year old) female istory significant for dementia, cellulitis (skin infection) and			VC	H/OL	C

PRINTED: 05/21/2015

PRINTED: 05/21/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDIC SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ C 495045 B. WING 05/13/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD MANORCARE HEALTH SERVICES-RICHMOND RICHMOND, VA 23228 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 16 F 323 hypertension (high blood pressure) who presents from (name of facility) via EMS (emergency medical system) with chief complaint of right leg pain. Per son, staff was getting pt (patient) changed after her morning bath and when they rolled her on her side, pt rolled out of bed and on to the floor. Pt has noted right lower leg deformity. Per son, pt communicated very minimally at baseline and is bed bound. Son reports that pt has been in pain and discomfort with any movement of right leg. Pt has never been seen by orthopedics (specialist that deals with bones). There are no other acute medical concerns at this time....Physical examination: Musculoskeletal - Angulation at distal two thirds of right tib fib (tibia and fibula). DP (dorsalis pedis) pulses intact. Moving toes well. Foot warm, no cold sensation. Contractures of both lower extremities left upper extremity, and digits of left hand. Palpated clavicles, shoulders, and elbows - no apparent pain or deformity except contractures. Palpated hips - no wincing d/t (due to) pain. Palpated left lower extremity contracture noted but no wincing d/t pain...Number of Diagnoses or Management Options: Diagnosis management comments; Impression: History of fall from the patient's bed at the nursing facility who has multiple contractures. On examination the patient does have a slight angulation to the distal one third of

RECEIVED

MAY 28 2015

VDH/OLC

her tib-fib on the right; x-ray confirms Baral

to be intact. Patient is unable to provide any history due to her dementia. Plan of care will be

further care based on their findings and

consult was surgery with probably splinting and

termination." The orthopedic consult documented, "X-RAY: Right tib-fib x-ray demonstrates fractures

fracture of the tibia with the comminuted fracture of the fibula. Distal neurovascular motor appears

		I AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495045	B. WING	; <u></u>			C / 13/2015
NAME OF I	PROVIDER OR SUPPLIER			l	REET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-RICHMOND		l	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	mid and distal thirds Segmental fibula fra (decrease in amoun IMPRESSION: Left fractures as describe AND PLAN: Difficul mental status, nona definitely treat this in to her significant kin nonoperative treatin put her in a very we splint, which is subset this situation. Will I weeks and then ho cast boot so that he regular basis by the	d fibula at the junction of the s. Spiral tibia fracture. acture. Severe osteopenia nt of bone tissue). t distal 1/3 tibia - fibula bed above. DISCUSSION It situation due to her altered ambulatory state. We will nonoperatively. However, due nee flexion contracture even ment is going to be difficult. I ell-padded short-leg posterior optimal but is our only option in leave this in place for 1-2 pefully put her in a removable er skin can be checked on a enursing home staff. I will try e delivered to the nursing		323			
	The comprehensive documented, "Focumobility, awareness "Interventions" docu "Administer medical created on 1/4/2013 Administer pain memonitor for effective and revised on 5/7/BIG BOY BED - crefull matt - created of 5/7/15 Low bed while residelevate bed lower at 1/4/2013 and revised Patient needs two 0	e care plan dated, 5/7/15, us: falls due to impaired s and hx (history) of falls." The umented: ation per physician order - 3 and updated on 5/7/15 edication as ordered and eness - created on 2/2/2010/15 eated on 5/12/15 on 1/4/2013 - cancelled on dent in bed. During care after care - created on ed on 5/7/15 CNAs (certified nursing adl (activities of daily living)			RECEI [®] MAY 28 VDH/O	201 5	

Provide assistance for resident during transfer

A BUILDING A BUILDING (X1) PROVIDER SUPPLIER 495045 NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-RICHMOND (X4) ID PRETE PROVIDER OR SUPPLIER (X5) ID PRETE PROVIDER OR SUPPLIER (X6) ID PRETE PROVIDER OR SUPPLIER (X6) ID PRETE PROVIDER STAN OF CORRECTION (X6) ID PRETE PROVIDER STAN OF CORRECTION (X6) ID PRETE PROVIDER OR ACTION SHOULD BE PRETE PROVIDER STAN OF CORRECTION (X6) ID PRETE PROVIDER OR ACTION SHOULD BE PRETE PROVIDER OR ACTION SHOULD B PRETE PROVIDER OR ACTION SHOULD B (X7) ID PRETE PROVIDER OR ACTION SHOULD B (X6) ID PRETE PROVIDER OR ACTION SHOULD B (X7) ID PRETE PROVIDER OR ACTION SHOULD B (X6) ID PRETE PROVIDER OR ACTION SHOULD B (X7) ID PRETE PROVIDER OR ACTION SHOULD B (X6) ID PRETE PROVIDER OR ACTION SHOULD B (X7) ID PRETE PROVIDER OR ACTION SHOULD B (X6) ID PRETE PROVIDER OR ACTION SHOULD B (X7) ID PRETE PROVIDER OR ACTION SHOULD B (X7) ID PRETE PROVIDER OR ACTION SHOULD B (X6) ID PRETE PROVI		MENT OF HEALTH	AND HUMAN SERVICES				FORM): 05/21/2015 MAPPROVED): 0938-0391
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-RICHMOND SUBMANY STATEMENT TO DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY TULL.) REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 18 with two CNAs - created on 1/4/2013 - revised on 5/7/15 Report development of pain, bruises, change in mental status, ADL function, appetite or neurological status per facility guidelines post fall - created on 1/4/2103 Scoop/perimeter mattress (a bed with foam that lines the perimeter of the bed to prevent accidental falls) (2) - created on 5/7/15, documented, "Summary of Alleged Incident. Staff repositioned resident on her side in bed to change linen. She reached over to her left side to pick up the sheet but the resident started to fall out of bed and the staff could not stop the resident from falling. Documents Reviewed: POC (plan of care): resident was tasked for one person assist for bathing and two person assist for bed mobility. Summary of Critical Information Obtained During Investigation: (Resident #1) 92 years (sic) old resident with HX (history) of dysphagia with expressive aphasia, dementia and multiple joint contractures. 05/07/15 hospital X-ray shown (sic) bone shown (sic) marked osteopenia with Baral fracture of the fibula. Resident was on a socop mattress. Staff pulled curtain to provide privacy. Staff tried to stop fall but was unsuccessful. Action Taken During Investigation: Resident assisted of (sic) the force and essessment convoleted. MID notified	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
MANORCARE HEALTH SERVICES-RICHMOND (XA) ID PRIEFIX TAG REGULATORY OR USE DEPTIFYING INFORMATION) F 323 Continued From page 18 with two CNAs - created on 1/4/2013 - revised on 5/7/15 Report development of pain, bruises, change in mental status, ADL function, appetite or neurological status per facility guidelines post fall - created on 1/4/2103 Scoop/perimeter mattress (a bed with foam that lines the perimeter of the bed to prevent accidental falls) (2) - created on 5/7/15 and resolved on 5/7/25) FALL RISK (FYI) (for your information) - created on 7/9/2010 - last revision on 9/17/2013." The facility incident report was requested. The incident report dated, 5/7/15, documented, "Summary of Alleged Incident: Staff repositioned resident on her side in bed to change linen. She reached over to her left side to pick up the sheet but the resident started to fall out of bed and the staff could not stop the resident from falling. Documents Reviewed: POC (plan of care); resident was tasked for one person assist for bathing and two person assist for bed mobility. Summary of Critical Information Obtained During Investigation: (Resident #1) 92 years (sic) old resident with HX (history) of dysphagia with expressive aphasia, dementia and multiple joint contractures. 05/07/15 hospital X-ray shown (sic) bone shown (sic) marked osteopenia with Baral fracture of the fiblua. Resident was on a scoop mattress. Staff pulled curtain to provide privacy. Staff tried to stop fall but was unsuccessful. Action Taken During Investigation: Resident as an as a scoop mattress.			495045	B. WING	i		05	
XX4 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCE WIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDED THE APPROPRIATE PROVIDED THE APPROPRIATE PROVIDED THE APPROPRIATE DATE F 323 Continued From page 18 with two CNAs - created on 1/4/2013 - revised on 5/7/15 Report development of pain, bruises, change in mental status, ADL function, appetite or neurological status per facility guidelines post fall - created on 1/4/2103 Scoop/perimeter mattress (a bed with foam that lines the perimeter of the bed to prevent accidental falls) (2) - created on 5/7/15 and resolved on 5/12/15 FALL RISK (FMT) (for your information) - created on 7/9/2010 - last revision on 9/17/2013." The facility incident report was requested. The incident report dated, 5/7/15, documented, "Summary of Alleged Incident: Staff repositioned resident on her side in bed to change linen. She reached over to her left side to pick up the sheet but the resident started to fall out of bed and the staff could not stop the resident from falling. Documents Reviewed: POC (plan of care): resident was tasked for one person assist for bed mobility. Summary of Critical Information Obtained During Investigation: (Resident #1) 92 years (sic.) old resident with HX (history) of dysphagia with expressive aphasia, dementia and multiple joint contractures. 05/07/15 hospital X-ray shown (sic.) bone shown (sic.) marked osteopenia with Baral fracture of the fibula. Resident was on a scoop mattress. Staff pulled curtain to provide privacy. Staff tried to stop fall but was unsuccessful. Action Taken During Investigation: Resident assisted of (sic.) the flore and assessment completed. MIO potified	NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
FREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) F 323 Continued From page 18 with two CNAs - created on 1/4/2013 - revised on 5/7/15 Report development of pain, bruises, change in mental status, ADL function, appetite or neurological status per facility guidelines post fall - created on 1/4/2103 Scoop/perimeter mattress (a bed with foam that lines the perimeter of the bed to prevent accidental falls) (2) - created on 5/7/15 and resolved on 5/12/15 FALL RISK (FYI) (for your information) - created on 7/8/2010 - last revision on 9/17/2013." The facility incident report was requested. The incident report dated, 5/7/15, documented, "Summary of Alleged Incident: Staff repositioned resident on her side in bed to change linen. She reached over to her left side to pick up the sheet but the resident started to fall out of bed and the staff could not stop the resident from falling. Documents Reviewed: POC (plan of care): resident was tasked for one person assist for bathing and two person assist for bed mobility, Summary of Critical Information Obtained During Investigation: (Resident #1) 92 years (sic) did resident with HX (history) of dysphagia with expressive aphasia, dementia and multiple joint contractures. OS/07/15 hospital X-ray shown (sic) bone shown (sic) marked osteopenia with Baral fracture of the fibula. Resident was on a scoop mattress. Staff pulled curtain to provide privacy. Staff tried to stop fall but was unsuccessful. Action Taken During Investigation: Resident assisted of (sic) the force and seasement completed. MD portified	MANOR	CARE HEALTH SERVI	CES-RICHMOND					
with two CNAs - created on 1/4/2013 - revised on 5/7/15 Report development of pain, bruises, change in mental status, ADL function, appetite or neurological status per facility guidelines post fall created on 1/4/2103 Scoop/perimeter mattress (a bed with foam that lines the perimeter of the bed to prevent accidental falls) (2) - created on 5/7/15 and resolved on 5/12/15 FALL RISK (FVI) (for your information) - created on 7/9/2010 - last revision on 9/17/2013." The facility incident report was requested. The incident report dated, 5/7/15, documented, "Summary of Alleged Incident: Staff repositioned resident on her side in bed to change linen. She reached over to her left side to pick up the sheet but the resident started to fall out of bed and the staff could not stop the resident from falling. Documents Reviewed: POC (plan of care): resident was tasked for one person assist for bathing and two person assist for bed mobility. Summary of Critical Information Obtained During Investigation: (Resident #1) 92 years (sic) old resident with HX (history) of dysphagia with expressive aphasia, dementia and multiple joint contractures. 05/07/15 hospital X-ray shown (sic) bone shown (sic) marked osteopenia with Baral fracture of the tibia with the comminuted fracture of the fibula. Resident was on a scoop mattress. Staff pulled curtain to provide privacy. Staff tried to stop fall but was unsuccessful. Action Taken During Investigation: Resident assisted of (sic) the floor and assessment completed. MD potified	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES.)	D BE	COMPLETION
and order obtained to transfer to ER for further VDH/OLC	F 323	with two CNAs - cre 5/7/15 Report developmer mental status, ADL neurological status - created on 1/4/210 Scoop/perimeter m lines the perimeter accidental falls) (2) resolved on 5/12/15 FALL RISK (FYI) {fo on 7/9/2010 - last re The facility incident incident report date "Summary of Allege resident on her side reached over to her but the resident sta staff could not stop Documents Review resident was tasked bathing and two per Summary of Critica Investigation: (Resi resident with HX (hi expressive aphasia contractures. 05/07 bone shown (sic) m fracture of the tibia of the fibula. Resid Staff pulled curtain to stop fall but was During Investigation the floor and assess	eated on 1/4/2013 - revised on at of pain, bruises, change in function, appetite or per facility guidelines post fall 03 attress (a bed with foam that of the bed to prevent - created on 5/7/15 and 5 or your information) - created evision on 9/17/2013." report was requested. The d, 5/7/15, documented, ed Incident: Staff repositioned e in bed to change linen. She refet side to pick up the sheet red to fall out of bed and the the resident from falling. POC (plan of care): d for one person assist for reon assist for reon assist for bed mobility. I Information Obtained During dent #1) 92 years (sic) old istory) of dysphagia with dementia and multiple joint 7/15 hospital X-ray shown (sic) tarked osteopenia with Baral with the comminuted fracture ent was on a scoop mattress. to provide privacy. Staff tried unsuccessful. Action Taken in: Resident assisted of (sic) sment completed. MD notified	F	323		à corre	

ok with plan. Resident sent to ER via EMS transportation. Staff interviewed and asked to

		AND HUMAN SERVICES			1	FOR	M APPROVED
	RS FOR MEDICARE OF DEFICIENCIES	& MEDIC SERVICES (X1) PROVIDER/SUPPLIER/CLIA	/Y2) MHH	TIDL	E CONSTRUCTION		D. 0938-0391 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		MPLETED
					DOTAL STATE OF THE		С
		495045	B. WING			0:	5/13/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-RICHMOND			125 HILLIARD ROAD ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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
E 222	Continued From pa		-	100			:
1 320	•	· · · · · · · · · · · · · · · · · · ·	F,	323			
		he repositioned resident. Staff eposition resident re-evaluated					
		compliance with facility					
		care plan was revised upon	: :				
		current LOC (level of care).					
		eview of resident POC (plan of					
		iplinary team) decisions to					
		'big boy bed' and some					
		tesident returned to facility, some respiratory wheezing,					
		MD called and notified. N.O.					•
	{	st x-ray which reviled (sic)					
		r po (by mouth) ABT					
		onsible party) made aware					
		onclusion: Resident does					:
		h her (hand) and is always					
		while in bed just resting. This					
		staff is provided care and this					
		sk that needed to be esident. staff did not have					:
		ent when she started falling to					
		ight have rolled her too far					
		or to her looking away to reach					
	for the linen resider	nt was at rest on her side in					
		esident has always been one					
		ped mobility with no incidents.					
		nge in respiratory status as					
		be concluded that resident					
		e be (sic) in the early onset on Attached to the incident					
		was the facility policies, "Bed		411,411	History Musting with manager of the comment	****	100
		and Bed Positioning." The			RECEIVE	D	
		pied" documented in part,					
		d staff member." Under			MAY 2 8 2015		AA manaa 110
		ocumented, "11. Have the					

side of bed."

second staff member on opposite side of bed from you as patient rolls...18. The second staff member will pull out dirty linen and make that

		AND HUMAN SERVICES				FORM	1 APPROVED
	RS FOR MEDICARE OF DEFICIENCIES	& MEDICA SERVICES	/V2) 141 II	171			. 0938-0391 TE SURVEY
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		MPLETED
							С
		495045	B. WING			05	/13/2015
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD		
MANORO	ARE HEALTH SERV	ICES-RICHMOND			RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 323	Continued From pa	age 20	F:	32	3		
	nursing assistant) # When asked how sassistance with carbe in place for a res#7 stated, "It's in the walls) under the Kaworks with Resider does periodically whow many staff me resident in moving two staff members An interview was comanager, RN (regist 10:07 a.m. When a to take care of a regresident has and here	onducted with the unit stered nurse) #2, on 5/13/15 at isked how the CNAs know how sident, what needs the ow much assistance a resident ated, "It's in the POC (plan of					
	staff member (ASM nursing, on 5/13/15 how a CNA caring t much assistance a	onducted with administrative 1) #3, the assistant director of 5 at 10:13 a.m. When asked for a resident determines how resident requires for care, 5 in the Kardex in the computer se."					
		sident #1 was requested. The d under the heading of	TOTAL PROPERTY.		RECEI	VED	
T provide the second se		Care - ADL assist - usually 1			MAY 28	2015	
Section of the sectio	CNA caring for the	onducted with CNA #8, the resident on 5/7/15 at 1:01 p.m. had taken care of Resident #1			VDH/C	LC	

prior to 5/7/15 the CNA stated that she had cared

PRINTED: 05/21/2015

		AND HUMAN SERVICES 8 MEDICA SERVICES				FORM	1 APPROVED
STATEMENT OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DAT	. 0938-0391 TE SURVEY MPLETED
		495045	B. WING				C / 13/2015
NAME OF PROV	VIDER OR SUPPLIER		<u>' </u>	Ę	STREET ADDRESS, CITY, STATE, ZIP CODE		10.20.5
MANORCAR	E HEA! TH SERV	ICES-RICHMOND		2	2125 HILLIARD ROAD		
WANDION.	E BLACH: VERT	TOES-NOTHINORD		F	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	ontinued From pa		F:	323	}		:
for car sta her sta her how res Kick (Re is a trains known exp sta the was she her on put off on of t Wh CN but info graphat res sta ma allo ma	her on multiple to red for the reside ated, "I did all of it rup. I did everyth wa CNA finds out it is a consider the eds. CN cosk. When asked esident #1), CNA as one person assunsferring her to a raide to side. The re of her. No one structed me to do ows how I take coplain what happeated, "I had washed draw sheet to pash her back. I water back by herself r, tucked them us her back so I put her on her right of her and turne the other bed and the bed that I water back if the IA #8 stated the IA #8 stated the IA #8 stated the IA #8 ows me to take conner. They just	times. When asked how she ent prior to the fall, CNA #8 it by myself, other than pulling hing by myself." When asked ut how much assistance a NA #8 stated she looks at the dhow many person assist is A #8 stated, She (Resident #1) sist but two persons for a chair, one person for rolling nat's how I was taught to take that ever questioned it or to otherwise. The manager care of her." When asked to ened that morning, CNA #8 ned the front of her and pulled the front of her and pulled that morning, CNA #8 ned the front of her and pulled the draw sheet again to a side again. I took my hands to the fell off the opposite side as on. I couldn't grab her. The resident moves on her own, resident does move her hands self from left to right. CNA #8 yor that the resident frequently the washcloth when she is a saked what kind of bed the the time of the fall, CNA #8 the check of the fall that the			RECEIV MAY 2 8 20 VDH/OL	S	

a handful. They thought I pulled the draw sheet

PRINTED: 05/21/2015

		AND HUMAN SERVICES & MEDIC SERVICES			O	FOF	ED: 05/21/2015 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION .		OATE SURVEY OMPLETED
		495045	B. WING			()5/13/2015
NAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	······································	, , , , , , , , , , , , , , , , , , ,
MANOR	CARE HEALTH SERVI	CES-RICHMOND			HILLIARD ROAD IMOND, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 22	F3	1 23			
	•	Her having a big boy bed now					· ·
	at 2:30 p.m. accom	ade of Resident #1 on 5/13/15 panied by CNA #8, ASM #3		:			
		ent #1 was observed in bed, on					•
		knees up near her chest. Her die					
		ned) at the hip at an					<u>:</u>
		gree angle with the hip. Her					į
		ontracted flat against the back					
		er right leg was contracted					:
	approximately 45 d	egrees, not as far as the left		I			
		as on the right lower leg. CNA					:
		escribe her actions as stated					
		ted the resident's contracted		İ			
		ing over the edge of the bed					
		IA #8 stated, "She rolled out of other bed and bounced back		1			11000
		e foot of the bed. The					1
	1	e on the floor at the middle					
		e had to raise the bed to get					
		nder the bed and get her up"					
	· •	CNA #8 that prior to the fall	:		•		
		on in the bed was with her					:
	f	f the bed and her contracted					:
	; -	of the bed. Then she rolled off					
		r head on the other bed and					
		ad at the foot of the bed on the	1	Andre Present			
		vere in the middle of the bed		4			
		bing the resident's body had)				
		from the position she had fall. RN #2 was asked how			RECE	VED	
		s it takes to make a bed with					
		ximately 175 - 200 pounds, in	:		MAY 28	2015	
		could be one or two."	: !				

An interview was conducted with ASM #2, the

	MENT OF HEALTH	I AND HUMAN SERVICES & MEDIC SERVICES				F	FORM A	05/21/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		X3) DATE COMF	SURVEY PLETED
		495045	B. WING	;	****		05/1	ੁ 13/2015
NAME OF F	PROVIDER OR SUPPLIER			I	REET ADDRESS, CITY, STATE, ZIP CO	ODE		0,
MANORO	CARE HEALTH SERVI	ICES-RICHMOND		I	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 PREF TAG	IX .	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
	asked how many stan occupied bed of move or assist with can be one or two scomfortable doing i feel uncomfortable help." When asked to how many people a judgment call." As (Resident #1) she hand we know her we knowing what we can is best for the patient requires more than mobility, the policy of for resident safety." On 5/13/15 at 3:26 #1) and ASM #2 we for harm. ASM #1 so in place after this an asked to present place of the policy of the patient of the policy in the policy it states judgment for how many staff members were that they use two per resident in it.	on 5/13/15 at 2:48 p.m. When taff members it takes to make a resident who is unable to a moving, ASM #2 stated, "It staff members. If I feel it by myself then I do it, but if I for any reason I would go get I who makes the judgment as the it takes, ASM #2 stated, "It's SM #2 further stated, "For has been here for six years well. There is a comfort line, can or cannot do. We do what tent. If we have someone who is two people for transfers or doesn't say that but we do that " p.m. the administrator (ASM ere made aware of the concern stated that they had put a plan accident occurred. ASM #1 was lan. on 3:56 p.m. and 4:10 p.m. two wed eight staff members, both regarding how many people it ad with a resident in bed, ately 175 - 200 pounds. All the able to inform the surveyors eople to make a bed with a p.m. ASM #2 met m. ASM #2 was asked where the staff may use their many person assist a resident		323	MA	ECEIV NY 2 8 2 DH/OI	2015	
:		g the bed with a resident in it, doesn't." ASM #1 was asked if						

	MENT OF HEALTH	AND HUMAN SERVICES & MEDIC SERVICES				FORM	05/21/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		495045	B, WING	i			C 13/2015
NAME OF F	PROVIDER OR SUPPLIER			l	REET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	CES-RICHMOND		l	25 HILLIARD ROAD CHMOND, 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 APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa	ago 24		300			
1 020		—		323			:
		low the policy on making an e their judgment, ASM #1		: :	•		
	stated, "They shoul		1	:			
	"Promoting Safety	and Comfort - the occupied					:
		erson lies on one side of the					
		ther. Protect the person from		:			
		f the person uses bed rails,		:			
		o. If the person does not use					
		ther person help you. You					
		f the bed. Your coworker					
	works on the other.	"Mosby's Essentials for		:			
		3rd edition; Sorrentino and					:
	Gorek, page 195.						
	On 5/13/15 at 4:30	p.m., ASM #1 and ASM #2					
		evidence that a five point plan					
	of correction had be	een put into place following the					
		ncident. The credible					
		d included the following:					
		itely called for help. Resident					
		ER for evaluation. Upon					
		osis of a tibia/fibula fracture,					
		t, Kardex, and care plan was					
	reviewed and revise						
		g 2 person assist and are or bed mobility have the					
		cted and will be reviewed to					
	•	assist is documented on in					
	the Task/Kardex.	. addict to addust office off at					
	3. Initiate investigat	ion and complete	!		RECEI	VFD	
		rvice aides on the bed		The Charles	- Section 1	V Sance Band	3
		e. In-service nurses on post	1	A CTAN PORTS	MAY 28	2015	
		Review facility process for	•	14			
	updating task/Karde	ex for ADL assist that is		1	VDH/O		
	identified on MDS a	and in-service staff who update	Ì		* 5 1 1/ 3		
		ew like patients to ensure ADL					
	assist according to	MDS is on task/Kardey and		- 1			

update Task/Kardex. Audit task/Kardex of all

	MENT OF HEALTH	AND HUMAN SERVICES & MEDIC SERVICES				FORM	05/21/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` СОМ	E SURVEY PLETED
		495045	B. WING				13/2015
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-RICHMOND		2.	TREET ADDRESS, CITY, STATE, ZIP CODE 125 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	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	according to MDS. 4. The center will remorning QAA (qual meeting to validate task/Kardex x 4 we ADL status on task, MDS assessment a audits to ensure co Audit/observation o with care will be coto. 5. 5/11/15. During the survey, to observation or recoto a resident while on the No further informatic COMPLAINT DEFINAT NON COMPLA	ADL assist is in place eview new residents through ity assurance) (name of room) ADL assist is one the eks. The center will update (Kardex as needed following and complete randon (sic) impliance x 4 weeks. Random if staff performing bed mobility impleted x4 weeks. In a concerns were identified by indered review with providing care changing the linens. In was provided prior to exit. CIENCY LIANCE ary of Medical Terms for the der, 5th edition, Rothenberg es 571, 227 and 141. Is obtained from the following Inlim.nih.gov/medlineplus/ ned Perimeter Mattress Cover inton solution to many of the sues affecting healthcare four 4 high wedge-shaped the side perimeters of the gentle reminder to those lying iss edges and help prevent in the bed. The openings in the or easy patient exit and entry th quick release buckles easily the bed.www.Posey.com	F	323	RECEIV MAY 2.8 VDH/O	2015	