STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495045	A. BUILDING _____ B. WING _____	C 05/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 5/12/15 through 5/13/15. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 194 certified bed facility was 147 at the time of the survey. The survey sample consisted of 4 current Residents reviews (Residents #1 through #4).	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have 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; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	**F225** It is the intended practice of this facility to follow our Patient Protection Practice Guide process. **Criteria 1** Resident #2's allegation was investigated and reported to the State Agencies as required by regulation on 5/14/2015 by the Administrator. **Criteria 2** An audit of investigations and concerns since March 1, 2015 was completed by the Administrator/designee to evaluate that investigations were completed.	06/05/15

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Elizabeth Nugent, LNHA — Elizabeth Nugent, LNHA — Administrator — 5/28/15

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.

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: 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 immediately report an allegation of abuse to the state agency for one of four residents in the survey sample, Resident #2. The family member of Resident #2 informed the facility staff, his mother told him she had been hit. The facility failed to report this allegation of abuse to the state agency. The findings include: Resident #2 was admitted to the facility on 9/8/14 with a recent readmission on 4/29/15 with diagnoses that included but were not limited to: sepsis (infection) with urinary tract infection, high blood pressure, dementia, congestive heart failure, pneumonia and history of deep vein thrombosis. The most recent MDS (minimum data set)	F 225	**Criteria 3** Staff reeducated on the Prevent Policy and procedure and reporting timely. **Criteria 4** The Administrator/designee will audit investigations weekly x4 weeks and monthly x2 months and report to QAA committee for review and recommendations. **Criteria 5** The facilities alleged date of compliance is June 5, 2015.	

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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 and notified of care perform (sic), state he was

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satisfied. Alert charting x (for) 72 (hours) for any changes. MD (medical doctor) notified, new order for u/a c/s (urinalysis, urine culture with sensitivities). At this noted resident is in bed resting."

An interview was conducted with CNA #7 on 5/13/15 at 9:56 a.m., regarding what she does if a family member tells her that their mother stated that they had been hit. CNA #7 stated, "First I make sure the resident is safe. I tell my charge nurse or supervisor. We need to protect the resident."

An interview was conducted with LPN (licensed practical nurse) #3 on 5/13/15 at 10:04 a.m. regarding the process he follows if a family member tells him that their mother stated that she had been hit. LPN #3 stated, "First I check the resident. Talk to the current caregiver and see if they know anything. I tell my supervisor and start the investigation." LPN #3 was asked if a resident having confusion changes the process to follow for an abuse allegation. LPN #3 stated, "No, it is an allegation of abuse and has to be investigated as such."

An interview was conducted with RN (registered nurse) #2, the unit manager, on 5/13/15 at 10:05 a.m., regarding what process she follows if a family member informed staff their mother has stated she was hit. RN #2 stated, "I ensure the resident's safety first and foremost. I call my supervisor or the administrator right away. We start the investigation immediately."

An interview was conducted with administrative staff member (ASM) #3, the assistant director of nursing, on 5/13/15 at 10:10 a.m., regarding the

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F 225	Continued From page 4	F 225		

facility procedure to be followed when a family member informs the staff that the parent (resident) stated they had been hit. ASM #3 stated, "First we make sure the resident is safe. We find out which staff member was caring for the resident. I call the DON (director of nursing) and the administrator and begin an investigation. When asked if the resident has a lower BIMS score, does that change anything in the investigation, ASM #3 stated, "No, we still must complete an investigation." ASM #3 was asked if a family member informing staff of a resident statement about being hit is considered an allegation of abuse. ASM #3 stated, "Absolutely."

An interview was conducted with the administrator (ASM #1) on 5/13/15 at 10:16 a.m., regarding the facility procedure to be followed when a family member informs the staff that the parent (resident) stated they had been hit. ASM #1 stated, "First we immediately start an investigation. We ensure the resident's safety. We question staff and proceed with the investigation. We suspend any staff member that may be involved until the investigation is 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 copy of the FRI was requested from the administrator regarding the allegation of abuse documented in the clinical record.

An interview was conducted with the ASM #1,

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administrator and ASM #3, assistant director of nursing on 5/13/15 at 11:00 a.m. ASM #1 stated that the facility did not file a FRI with the state agency. ASM #1 stated, "I spoke with the manager on duty (MOD) and she checked on the resident. A concern form was created, it's an internal form. The MOD and the nurse checked on the resident. They got her statement, assessed the skin. The resident had changed her story. We called the nurse manager on duty and called her in to assess the resident and start the investigation. She interviewed the resident and the resident changed her story and had not stated any concerns for abuse or mistreatment." When asked if this was not an allegation of abuse, ASM #1 stated, "The resident changed her story. We did not feel it was an allegation of abuse so we treated it as a concern to rule out abuse and neglect. When asked if a concern or allegation of abuse only come from a resident, ASM #1 stated, "No, it can come from the family, staff, residents or visitors." When asked then if there is an allegation of someone being hit brought to your attention by a family member was that not considered an allegation of abuse, ASM #1 stated, "He wanted someone to check on his mother. He was concerned about her." The nurse's note dated, 4/25/15 at 5:39 p.m. was reviewed with ASM #1. ASM #1 stated, "The nurse's first sentence is incorrect according to my conversation with the nurse manager." ASM #3 informed this surveyor that the nurse (RN #3) was in the building. An interview was requested with RN #3.

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

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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 state survey and certification agency)."

ASM #1 and ASM #2 were made aware of these findings on 5/13/15 at 3:26 p.m.

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F 225	Continued From page 7 No further information was provided prior to exit.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 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 implement policies and procedures to report an allegation of abuse to the state agency for one of four residents in the survey sample, Resident #2. The facility staff failed to implement their policy to immediately report an allegation of abuse to the state agency. On 4/25/15 Resident #2's son reported to facility staff that his mother (Resident #2) stated she had been hit. The facility staff failed to immediately report this allegation of abuse to the state agency. The findings include: Resident #2 was admitted to the facility on 9/8/14 with a recent readmission on 4/29/15 with diagnoses that included but were not limited to: sepsis (infection) with urinary tract infection, high blood pressure, dementia, congestive heart failure, pneumonia and history of deep vein thrombosis.	F 226	**F226** It is the intended practice of this facility to follow our Patient Protection Practice Guide process. **Criteria 1** Resident #2's allegation was investigated and reported to the State Agencies as required by regulation on 5/14/2015 by the Administrator. **Criteria 2** An audit of investigations and concerns since March 1, 2015 was completed by the Administrator/designee to evaluate that investigations were completed. **Criteria 3** Staff reeducated on the Prevent Policy and procedure and reporting timely. **Criteria 4** The Administrator/designee will audit investigations weekly x4 weeks and monthly x2 months and report to QAA committee for review and recommendations. **Criteria 5** The facilities alleged date of compliance is June 5, 2015.	06/05/15

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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 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

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and notified of care perform (sic), state he was satisfied. Alert charting x (for) 72 (hours) for any changes. MD (medical doctor) notified, new order for u/a c/s (urinalysis, urine culture with sensitivities). At this noted resident is in bed resting."

An interview was conducted with CNA #7 on 5/13/15 at 9:56 a.m., regarding what she does if a family member tells her that their mother stated that they had been hit. CNA #7 stated, "First I make sure the resident is safe. I tell my charge nurse or supervisor. We need to protect the resident."

An interview was conducted with LPN (licensed practical nurse) #3 on 5/13/15 at 10:04 a.m. regarding the process he follows if a family member tells him that their mother stated that she had been hit. LPN #3 stated, "First I check the resident. Talk to the current caregiver and see if they know anything. I tell my supervisor and start the investigation." LPN #3 was asked if a resident having confusion changes the process to follow for an abuse allegation. LPN #3 stated, "No, it is an allegation of abuse and has to be investigated as such."

An interview was conducted with RN (registered nurse) #2, the unit manager, on 5/13/15 at 10:05 a.m., regarding what process she follows if a family member informed staff their mother has stated she was hit. RN #2 stated, "I ensure the resident's safety first and foremost. I call my supervisor or the administrator right away. We start the investigation immediately."

An interview was conducted with administrative staff member (ASM) #3, the assistant director of

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nursing, on 5/13/15 at 10:10 a.m., regarding the facility procedure to be followed when a family member informs the staff that the parent (resident) stated they had been hit. ASM #3 stated, "First we make sure the resident is safe. We find out which staff member was caring for the resident. I call the DON (director of nursing) and the administrator and begin an investigation. When asked if the resident has a lower BIMS score, does that change anything in the investigation, ASM #3 stated, "No, we still must complete an investigation." ASM #3 was asked if a family member informing staff of a resident statement about being hit is considered an allegation of abuse. ASM #3 stated, "Absolutely."

An interview was conducted with the administrator (ASM #1) on 5/13/15 at 10:16 a.m., regarding the facility procedure to be followed when a family member informs the staff that the parent (resident) stated they had been hit. ASM #1 stated, "First we immediately start an investigation. We ensure the resident's safety. We question staff and proceed with the investigation. We suspend any staff member that may be involved until the investigation is 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 copy of the FRI was requested from the administrator regarding the allegation of abuse documented in the clinical record.

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An interview was conducted with the ASM #1, administrator and ASM #3, assistant director of nursing on 5/13/15 at 11:00 a.m. ASM #1 stated that the facility did not file a FRI with the state agency. ASM #1 stated, "I spoke with the manager on duty (MOD) and she checked on the resident. A concern form was created, it's an internal form. The MOD and the nurse checked on the resident. They got her statement, assessed the skin. The resident had changed her story. We called the nurse manager on duty and called her in to assess the resident and start the investigation. She interviewed the resident and the resident changed her story and had not stated any concerns for abuse or mistreatment." When asked if this was not an allegation of abuse, ASM #1 stated, "The resident changed her story. We did not feel it was an allegation of abuse so we treated it as a concern to rule out abuse and neglect. When asked if a concern or allegation of abuse only come from a resident, ASM #1 stated, "No, it can come from the family, staff, residents or visitors." When asked then if there is an allegation of someone being hit brought to your attention by a family member was that not considered an allegation of abuse, ASM #1 stated, "He wanted someone to check on his mother. He was concerned about her." The nurse's note dated, 4/25/15 at 5:39 p.m. was reviewed with ASM #1. ASM #1 stated, "The nurse's first sentence is incorrect according to my conversation with the nurse manager." ASM #3 informed this surveyor that the nurse (RN #3) was in the building. An interview was requested with RN #3.

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

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she had read the note RN #3 was asked to 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 state survey and certification agency)."

ASM #1 and ASM #2 were made aware of these findings on 5/13/15 at 3:26 p.m.

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F 226	Continued From page 13 No further information was provided prior to exit.	F 226		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, 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 ensure resident safety while changing bed linens to prevent harm for one of four residents in the survey sample, Resident #1. On 5/7/15 CNA (certified nursing assistant) #8 rolled Resident #1 onto her right side using a draw sheet to change the bed linens. CNA #8 took her hands off the resident, turned to grab the sheets and Resident #1 fell off the opposite side of the bed onto the floor. Resident #1 sustained a tibia* and fibula** fracture of the right leg as result of the fall. * 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)	F 323	Past noncompliance: no plan of correction required.	

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Resident #1 fell off the bed during a linen change and fractured both bones in her right leg.

The findings include:

Resident #1 was admitted to the facility on 9/20/09 with a readmission on 9/17/13 with diagnoses that included but were not limited to: anemia, dementia, dysphagia (difficulty swallowing) ^, aphasia (difficulty speaking) ^, stroke, history of pneumonia and recent fractures of the tibia and fibula.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/26/15, coded the resident as sometimes understanding others and sometimes making herself understood. Resident #1 was coded as being highly visually impaired, object identification in question, but eyes appear to follow objects. It was coded that the resident was unable to answer the questions on the BIMS (brief interview for mental status). The staff interview coded the resident with both short and long term memory difficulties. The resident was coded as being severely impaired, indicating that she never/rarely made decisions of daily life. In Section G - Functional Status, Resident #1 was coded as being totally dependent upon two staff members for moving to and from a lying position, turning side to side and positioning body while in bed. In Section G0400 - Functional Limitation in Range of Motion, code for limitation that interfered with daily functions or placed resident at risk of injury, the resident was coded as having impairment of both lower extremities and one side of her upper extremities. Resident #1 was

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coded in Section K - Swallowing and Nutrition as weighing 175 pounds.

Observation was made of Resident #1 on 5/12/15 at 5:45 p.m. and 6:15 p.m. The resident was lying in bed with the head of the bed elevated. A tube feeding was infusing at this time. The resident was awake but non-communicative. The resident's back was on the surface of the bed. The resident's knees were up near her chest slightly angled to the left side of the resident. She had contractures (an abnormal, usually permanent contraction of a muscle due to atrophy of muscle fibers) (1) of her left arm and hand. She was moving her right hand over the edges of her covers. Resident #1 was in a regular standard size bed. Resident #1 was again observed on 5/13/15 at 8:03 a.m. in a larger size bed. Resident appeared to be sleeping.

The clinical record was reviewed on 5/13/14 at approximately 10:30 a.m. The nurse's notes dated 5/7/15 at 9:41 a.m., documented, "Pt (patient) fell during patient care. Assessment completed, primary nurse notified NP (nurse practitioner). New orders given to send resident to hospital for evaluation. Writer spoke with son about fall. Son ok for resident to (be sent to) (name of hospital) ER (emergency room). Son said he is leaving work now to go to the ER to meet Mom."

The hospital records were reviewed. The emergency room physician documented on 5/7/15 at 11:19 a.m., "92 y. o. (year old) female with past medical history significant for dementia, dysphagia, sepsis, cellulitis (skin infection) and

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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 her tib-fib on the right; x-ray confirms Baral fracture of the tibia with the comminuted fracture of the fibula. Distal neurovascular motor appears to be intact. Patient is unable to provide any history due to her dementia. Plan of care will be consult was surgery with probably splinting and further care based on their findings and termination." The orthopedic consult documented, "X-RAY: Right tib-fib x-ray demonstrates fractures

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of both the tibia and fibula at the junction of the mid and distal thirds. Spiral tibia fracture. Segmental fibula fracture. Severe osteopenia (decrease in amount of bone tissue). IMPRESSION: Left distal 1/3 tibia - fibula fractures as described above. DISCUSSION AND PLAN: Difficult situation due to her altered mental status, nonambulatory state. We will definitely treat this nonoperatively. However, due to her significant knee flexion contracture even nonoperative treatment is going to be difficult. I put her in a very well-padded short-leg posterior splint, which is suboptimal but is our only option in this situation. Will leave this in place for 1-2 weeks and then hopefully put her in a removable cast boot so that her skin can be checked on a regular basis by the nursing home staff. I will try order the boot to be delivered to the nursing home next week or the week after."

The comprehensive care plan dated, 5/7/15, documented, "Focus: falls due to impaired mobility, awareness and hx (history) of falls." The "Interventions" documented:
"Administer medication per physician order - created on 1/4/2013 and updated on 5/7/15
Administer pain medication as ordered and monitor for effectiveness - created on 2/2/2010 and revised on 5/7/15
BIG BOY BED - created on 5/12/15
Fall matt - created on 1/4/2013 - cancelled on 5/7/15
Low bed while resident in bed. During care elevate bed lower after care - created on 1/4/2013 and revised on 5/7/15
Patient needs two CNAs (certified nursing assistants) during adl (activities of daily living) care - created on 5/7/15
Provide assistance for resident during transfer

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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 7/9/2010 - 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 notified and order obtained to transfer to ER for further evaluation. Resident representative notified and ok with plan. Resident sent to ER via EMS transportation. Staff interviewed and asked to

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demonstrate how she repositioned resident. Staff ability to turn and reposition resident re-evaluated and found to be in compliance with facility protocol. Resident care plan was revised upon re-admit to reflect current LOC (level of care). 5/12/15 on further review of resident POC (plan of care) IDT (interdisciplinary team) decisions to change resident to 'big boy bed' and some agreed with plan. Resident returned to facility, found to be having some respiratory wheezing, distress and fever. MD called and notified. N.O. (new order) for chest x-ray which reviled (sic) bronchitis. N.O. for po (by mouth) ABT (antibiotic) RP responsible party) made aware and ok with plan. Conclusion: Resident does reach for things with her (hand) and is always playing with hands while in bed just resting. This is not the first time staff is provided care and this was an assigned task that needed to be completed for this resident. staff did not have hands on the resident when she started falling to suggest that she might have rolled her too far suggesting that prior to her looking away to reach for the linen resident was at rest on her side in bed. Since 2010 resident has always been one person assist with bed mobility with no incidents. Given resident change in respiratory status as noted above, it can be concluded that resident condition could have be (sic) in the early onset on the day of the fall." Attached to the incident report/investigation was the facility policies, "Bed Making: Occupied and Bed Positioning." The "Bed Making: Occupied" documented in part, "Equipment: Second staff member." Under "Procedure" was documented, "11. Have the 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 side of bed."

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An interview was conducted with CNA (certified nursing assistant) #7 on 5/13/15 at 9:57 a.m. When asked how she finds out what type of care, assistance with care, safety devices that need to be in place for a resident she is caring for, CNA #7 stated, "It's in the Kiosk (computer on the walls) under the Kardex." When asked if she works with Resident #1, CNA #7 stated that she does periodically work with her. When asked how many staff members it takes to assist the resident in moving in the bed, CNA #7 stated, "its two staff members at all times."

An interview was conducted with the unit manager, RN (registered nurse) #2, on 5/13/15 at 10:07 a.m. When asked how the CNAs know how to take care of a resident, what needs the resident has and how much assistance a resident requires, RN #2 stated, "It's in the POC (plan of care) on the kiosk. It's the Kardex."

An interview was conducted with administrative staff member (ASM) #3, the assistant director of nursing, on 5/13/15 at 10:13 a.m. When asked how a CNA caring for a resident determines how much assistance a resident requires for care, ASM #3 stated, "It's in the Kardex in the computer and the charge nurse."

The Kardex for Resident #1 was requested. The Kardex documented under the heading of "ADLs/Restorative Care - ADL assist - usually 1 person with extensive level of assist."

An interview was conducted with CNA #8, the CNA caring for the resident on 5/7/15 at 1:01 p.m. When asked if she had taken care of Resident #1 prior to 5/7/15 the CNA stated that she had cared

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for her on multiple times. When asked how she cared for the resident prior to the fall, CNA #8 stated, "I did all of it by myself, other than pulling her up. I did everything by myself." When asked how a CNA finds out how much assistance a resident needs, CNA #8 stated she looks at the Kiosk. When asked how many person assist is (Resident #1), CNA #8 stated, She (Resident #1) is a one person assist but two persons for transferring her to a chair, one person for rolling her side to side. That's how I was taught to take care of her. No one has ever questioned it or instructed me to do otherwise. The manager knows how I take care of her." When asked to explain what happened that morning, CNA #8 stated, "I had washed the front of her and pulled the draw sheet to put her on her side so I could wash her back. I washed her back. I had the sheets on the next bed. She does roll back on her back by herself. I put the dirty sheets under her, tucked them under her. She had fallen back on her back so I pulled the draw sheet again to put her on her right side again. I took my hands off of her and turned to my left to grab the sheets on the other bed and she fell off the opposite side of the bed that I was on. I couldn't grab her. When asked if the resident moves on her own, CNA #8 stated the resident does move her hands but can't move herself from left to right. CNA #8 informed the surveyor that the resident frequently grabs her hands or the washcloth when she is bathing her." When asked what kind of bed the resident was on at the time of the fall, CNA #8 stated, "A regular bed, small bed with a scoop mattress." CNA #8 stated, "(Name of RN #2) allows me to take care of (Resident #1) in that manner. They just let me do her by myself. I've never been told otherwise. She's (Resident #1) is a handful. They thought I pulled the draw sheet

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too far but I didn't. Her having a big boy bed now is much better."

Observation was made of Resident #1 on 5/13/15 at 2:30 p.m. accompanied by CNA #8, ASM #3 and RN #2. Resident #1 was observed in bed, on her back, with her knees up near her chest. Her left leg is contracted (permanently fixed and cannot be straightened) at the hip at an approximate 35 degree angle with the hip. Her left lower leg was contracted flat against the back of the left thigh. Her right leg was contracted approximately 45 degrees, not as far as the left leg. A hard cast was on the right lower leg. CNA #8 was asked to describe her actions as stated above. CNA #8 stated the resident's contracted knees were extending over the edge of the bed prior to the fall. CNA #8 stated, "She rolled out of the bed, she hit the other bed and bounced back with her head at the foot of the bed. The resident's legs were on the floor at the middle level of the bed. We had to raise the bed to get her legs out from under the bed and get her up" It was clarified with CNA #8 that prior to the fall the resident's position in the bed was with her head at the head of the bed and her contracted legs in the middle of the bed. Then she rolled off the bed, striking her head on the other bed and landing with her head at the foot of the bed on the floor and her legs were in the middle of the bed on the floor. Describing the resident's body had turned 180 degrees from the position she had been on before the fall. RN #2 was asked how many staff members it takes to make a bed with a resident of approximately 175 - 200 pounds, in it, RN #2 stated, "It could be one or two."

An interview was conducted with ASM #2, the

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director of nursing, on 5/13/15 at 2:48 p.m. When asked how many staff members it takes to make an occupied bed of a resident who is unable to move or assist with moving, ASM #2 stated, "It can be one or two staff members. If I feel comfortable doing it by myself then I do it, but if I feel uncomfortable for any reason I would go get help." When asked who makes the judgment as to how many people it takes, ASM #2 stated, "It's a judgment call." ASM #2 further stated, "For (Resident #1) she has been here for six years and we know her well. There is a comfort line, knowing what we can or cannot do. We do what is best for the patient. If we have someone who requires more than two people for transfers or mobility, the policy doesn't say that but we do that for resident safety."

On 5/13/15 at 3:26 p.m. the administrator (ASM #1) and ASM #2 were made aware of the concern for harm. ASM #1 stated that they had put a plan in place after this accident occurred. ASM #1 was asked to present plan.

On 5/13/14 between 3:56 p.m. and 4:10 p.m. two surveyors interviewed eight staff members, both CNAs and nurses regarding how many people it takes to make a bed with a resident in bed, weighing approximately 175 - 200 pounds. All staff members were able to inform the surveyors that they use two people to make a bed with a resident in it.

On 5/13/15 at 4:30 p.m. ASM #1 and ASM #2 met with the survey team. ASM #2 was asked where in the policy it states that the staff may use their judgment for how many person assist a resident needs for changing the bed with a resident in it, ASM #2 stated, "It doesn't." ASM #1 was asked if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495045	A. BUILDING _____ B. WING _____	C 05/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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the staff were to follow the policy on making an occupied bed or use their judgment, ASM #1 stated, "They should follow the policy."

"Promoting Safety and Comfort - the occupied bed: Safety - The person lies on one side of the bed and then the other. Protect the person from falling out of bed. If the person uses bed rails, the far bed rail is up. If the person does not use bed rails, have another person help you. You work on one side of the bed. Your coworker works on the other."Mosby's Essentials for Nursing Assistants, 3rd edition; Sorrentino and Gorek, page 195.

On 5/13/15 at 4:30 p.m., ASM #1 and ASM #2 presented credible evidence that a five point plan of correction had been put into place following the above referenced incident. The credible evidence presented included the following:
1. CNA #8 immediately called for help. Resident #1 was sent to the ER for evaluation. Upon return, with a diagnosis of a tibia/fibula fracture, the fall assessment, Kardex, and care plan was reviewed and revised.
2. Patients requiring 2 person assist and are totally dependent for bed mobility have the potential to be affected and will be reviewed to ensure level of ADL assist is documented on in the Task/Kardex.
3. Initiate investigation and complete investigation. In-service aides on the bed positioning guidance. In-service nurses on post fall documentation. Review facility process for updating task/Kardex for ADL assist that is identified on MDS and in-service staff who update Task/Kardex. Review like patients to ensure ADL assist according to MDS is on task/Kardex and update Task/Kardex. Audit task/Kardex of all

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residents to ensure ADL assist is in place according to MDS.
4. The center will review new residents through morning QAA (quality assurance) (name of room) meeting to validate ADL assist is one the task/Kardex x 4 weeks. The center will update ADL status on task/Kardex as needed following MDS assessment and complete randon (sic) audits to ensure compliance x 4 weeks. Random Audit/observation of staff performing bed mobility with care will be completed x4 weeks.
5. 5/11/15.
During the survey, no concerns were identified by observation or record review with providing care to a resident while changing the linens.
No further information was provided prior to exit.
COMPLAINT DEFICIENCY
PAST NON COMPLIANCE

(1) Barron's Dictionary of Medical Terms for the Non - Medical Reader, 5th edition, Rothenberg and Chapman, pages 571, 227 and 141.
^all information was obtained from the following website: http://www.nlm.nih.gov/medlineplus/
(2) The Posey Defined Perimeter Mattress Cover offers a low intervention solution to many of the side rail restraint issues affecting healthcare facilities today. The four 4 high wedge-shaped foam sections line the side perimeters of the mattress, provide a gentle reminder to those lying in bed of the mattress edges and help prevent accidental falls from the bed. The openings in the mid-section allow for easy patient exit and entry and the 8 straps with quick release buckles easily secure the cover to the bed.www.Posey.com <http://www.Posey.com>