DEDAD	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 04/27/2017 FORM APPROVED
	RS FOR MEDICARE	* 1			OMB NO. 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495283	B. WING		04/20/2017
NAME OF	PROVÍDER OR SÚPPLIER		1	STREET AUDRESS, CITY, STATE, ZIP C	
	· · · · ·			1719 BELLEVUE AVENUE	•
MANOR	CARE HEALTH SERV	ICES-IMPERIAL		RICHMOND, VA 23227	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 000	INITIAL COMMENT	rs	F 00	00	
	survey was conduct Complaints were in	Life Safety Code			
F 278 SS=D	113 at the time of the consisted of 20 cur (Residents 1 throug reviews (Residents 483.20(q)-(j) ASSES		F 27	78	
		essments. The assessment ect the resident's status.			
	(h) Coordination A registered nurse reach assessment we participation of health				
	(i) Certification (1) A registered nurs the assessment is c	se must sign and certify that ompleted.			
		who completes a portion of the gn and certify the accuracy of seesment.			ECEIVED
				M	AY 09 2017
	(j) Penalty for Falsific (1) Under Medicare who willfully and known	and Medicaid, an individual		V	DHVOLC
					1
ABORATORY	POIRECTOR'S OR PROVIDE	RUSUPPHER REPRESENTATIVE'S SIGN	IATURE	TITLE	51 8 17

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.

Facility ID: VA0154

	MENT OF HEALTH	AND HUMAN SERVICES & MEDIC SERVICES				FORM	: 04/27/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COV	E SURVEY MPLETED
		495283	B. WING	;		1	C / <b>20/2017</b>
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		171	EET ADDRESS, CITY, STATE, ZIP CODE  9 BELLEVUE AVENUE  CHMOND, VA 23227		
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F 278	résident assessmer	ge 1 ial and false statement in a nt is subject to a civil money than \$1,000 for each	F	278 ·	F 278  Corrective Action:		5/22/19
	and false statement subject to a civil mo \$5,000 for each ass (2) Clinical disagree material and false s	ement does not constitute a			On 4/19/17, a modification to a prior assessment for Section O for resident #3 was completed to accurately reflect the resident's flu vaccine status.	y	
	Based on staff inter review, it was determated to complete a	rview and clinical record mined that the facility staff n accurate MDS (minimum nt for one of 25 residents in Resident # 3.			Other Potential Resider Affected:	nts	5/əə/1
	correct date of Residuaccination on the q	uarterly MDS (minimum data h an ARD (assessment			Other residents who require Section O of an MDS assess to be completed had the potential to be affected.		
	The findings include	ı <b>t</b>					
	10/18/16 with diagnolimited to: Parkinson diabetes mellitus (3)	dmitted to the facility on oses that included but not o's disease (1), dysphagia (2), gastroesophageal reflux sion, glaucoma (5) and ose (6).			RECE MAY 0		
	quarterly assessmen	OS (minimum data set), a nt with an ARD (assessment 1/22/17 coded Resident # 3			VDH/		

as scoring a 15 on the brief interview for mental

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

	PRINTED: 04/27/2017
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	ND PLAN OF CORRECTION   IDENTIFICATION NUMBER: A. BUILDING COM			E SURVEY IPLETED			
	:	495283	B. WING			1	C <b>20/2017</b>
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	s <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE	1 047	20/2011
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				719 BELLEVUE AVENUE		
MANOR	CARE HEALTH SERVI	CES-IMPERIAL		RICHMOND, VA 23227			
(VA) ID	SHAMARYSTA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 278	Continued From pa	ge 2	F 2	278	Systematic Changes:		5/22/11
	status (BIMS) of a s	score of 0 - 15, 15 being					
	cognitively intact for	r daily decision making.			Beginning 4/19/17, an audit		
		oded as requiring extensive			of Section O was completed		
		taff member for activities of B0700 "Makes Self			for coding accuracy for curren	nt	
		Resident # 3 as "Understood"			residents who require MDS	16	- VI
		"Able To Understand Others"			assessments with discrepance	.00	
		as "Understands - clear		:	-	£2	
		ection O0250 "Influenza		:	noted and/or corrected as		
		Resident # 3 a "0 (zero). No. finfluenza vaccine not			applicable and appropriate		
		on." Under section O0250C			per RAI guidelines.		
		oded "9 (nine). None of the					
	above."	2			Beginning 4/20/17, staff		o de deservación de la constante de la constan
	Pavious of Pasidont	# 3's electronic clinical record			who complete MDS assessme		
;		(electronic medication			were re-educated by the Regi	onal	
		rd) dated November 2017.			case mix Specialist regarding		
		nted, "Flu (influenza) 0.5 ml			the importance of completing	5	
		only for the flu vaccine er review of the eMAR			Section O accurately per the		
		cine was administered on			RAI guidelines.		
	11/11/16 at 4:34 p.n						
		5 a.m. an interview was (registered nurse) # 6, a MDS					
	coordinator. RN#6	was asked to review Section accination of Resident # 3's					
		the ARD of 01/22/17 and the					
		ord" for Resident # 3. When				APPEA	
		crepancy between the MDS on record for Resident # 3, RN			RECE	veu	
		s not coded correctly." When					
		ce is used for completing the			MAY 09	701/	
		she uses the RAI (Resident			VDH/	OLC	
	Assessment Instrun	nent) manual.			W J W W		

The RAI (Resident Assessment Instrument) manual documented, " O0250: Influenza Vaccine.

#### PRINTED: 04/27/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING \_ B. WING 495283 04/20/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1719 BELLEVUE AVENUE** MANORCARE HEALTH SERVICES-IMPERIAL RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 278 Continued From page 3 F 278 **Monitoring System:** Steps for Assessment 1. Review the resident's medical record to Beginning 5/8/17, a weekly determine whether an influenza vaccine was random audit of 10 MDS received in the facility for this year's influenza assessments will be reviewed vaccination season. If vaccination status is unknown, proceed to the next step. for accuracy validation by 2. Ask the resident if he or she received an the Administrator and/or her influenza vaccine outside of the facility for this designee for compliance per vear's influenza vaccination season. If vaccination status is still unknown, proceed to the next step. the RAI guidelines. 3. If the resident is unable to answer, then ask the same question of the responsible party/legal Audits will be conducted for guardian and/or primary care physician. If four weeks and then monthly influenza vaccination status is still unknown. proceed to the next step. for two months thereafter. 4. If influenza vaccination status cannot be determined, administer the influenza vaccine to Identified discrepancies will the resident according to standards of clinical be addressed accordingly and/or practice. Coding Instructions for O0250A, Did the resident as appropriate. receive the influenza vaccine in this facility for this vear's influenza vaccination season? Such will be forwarded to the Code 0, no: if the resident did NOT receive the influenza vaccine in this facility during this year's QA&A Committee for further influenza vaccination season. Proceed to If review and/or possible revisions influenza vaccine not received state reason to facility protocol. (O0250C). o Code 1, yes: if the resident did receive the influenza vaccine in this facility during this year's

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01-17-2014.

vaccine received

influenza season. Continue to Date influenza

Coding Instructions for O0250B, Date influenza

o Enter the date that the influenza vaccine was received. Do not leave any boxes blank.

- If the month contains only a single digit, fill in the first box of the month with a "0". For example, January 17, 2014 should be entered as

vaccine received (O0250B).

PRINTED: 04/27/2017 DEPARTMENT OF HEALTH AND HUM **N SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDIÓ SERVICES 🖒 OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIÉNCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 495283 B. WING 04/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1719 BELLEVUE AVENUE** MANORCARE HEALTH SERVICES-IMPERIAL **RICHMOND, VA 23227** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 278 Continued From page 4 F 278 - If the day only contains a single digit, then fill the first box of the day with the "0". For example, October 6, 2013 should be entered as 10-06-2013. A full 8 character date is required. - A full 8 character date is required. If the date is unknown or the information is not available, only a single dash needs to be entered in the first box. Coding Instructions for O0250C, If influenza vaccine not received, state reason If the resident has not received the influenza vaccine for this year's influenza vaccination season (i.e., O0250A=0), code the reason from the following list: o Code 1, Resident not in this facility during this year's influenza vaccination season: resident was not in this facility during this year's influenza vaccination season. o Code 2. Received outside of this facility: includes influenza vaccinations administered in any other setting (e.g., physician office, health fair, grocery store, hospital, fire station) during this year's influenza vaccination season. o Code 3, Not eligible-medical contraindication: if influenza vaccine not received due to medical contraindications. Contraindications include, but are not limited to; allergic reaction to eggs or other vaccine component(s) (e.g., thimerosal preservative), previous adverse reaction to influenza vaccine, a physician order not to immunize, moderate to severe illness with or

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vaccination.

vaccination.

without fever, and/or history of Guillain-Barré

o Code 4, Offered and declined: resident or

influenza vaccine and chooses not to accept

o Code 5, Not offered: resident or responsible

responsible party/legal guardian has been

Syndrome within 6 weeks of previous influenza

informed of the risks and benefits of receiving the

		I AND HUMAN SERVICES E & MEDICO SERVICES				FORM	): 04/27/2017 MAPPROVED
STATEMENT	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.			(X3) DAT	). 0938-0391 TE SURVEY MPLETED
		495283	B. WING			1	C <u>/20/2017</u>
NAME OF F	PROVIDER OR SUPPLIER		A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 278  due at e at e at the e sted //as // # f the  xit.				
MANORO	CARE HEALTH SERVI	ICES-IMPERIAL					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
F 278	vaccine. o Code 6, Inability to a declared shortathis facility due to a shortage. o Code 9, None of treasons describe w not administered. Transwer." On 04/19/17 at 4:00	age 5 In not offered the influenza Ito obtain influenza vaccine due age: vaccine is unavailable at a declared influenza vaccine Ithe above: if none of the listed Ithe hybrid the influenza vaccine was This code is also used if the In p.m. ASM (administrative the administrator, and ASM #	A the contract of the contract	!78			
:	2, the director of nu findings.						
	No further information	ion was obtained prior to exit.					
	References:						
		nent disorder. This tained from the website: n.gov/medlineplus/parkinsonsdi					
	obtained from the w	sorder. This information was vebsite:  .gov/medlineplus/swallowingdi					
		se in which the body cannot			REC	EIVEL	<b>)</b>
	information was obta	t of sugar in the blood. This ained from the website:		•		0.9 2017	
	https://www.nlm.nih.	.gov/medlineplus/ency/article/			MAI	03 201	

was obtained from the website:

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information

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#### PRINTED: 04/27/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDI® SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 495283 04/20/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1719 BELLEVUE AVENUE MANORCARE HEALTH SERVICES-IMPERIAL **RICHMOND, VA 23227** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 309 F 278 F 278 Continued From page 6 https://www.nlm.nih.gov/medlineplus/gerd.html. Corrective Action: (5) A group of diseases that can damage the eye's optic nerve. This information was obtained from the website: On 4/18/17, the MD for https://www.nlm.nih.gov/medlineplus/glaucoma.ht resident #1 was notified of ml. a medication (Ativan) omission (6) Kidneys are damaged and can't filter blood as with no new orders given. they should. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/chronickidne ydisease.html. **Other Potential Residents** 5/22/11 F 309 F 309 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES Affected: SS=D FOR HIGHEST WELL BEING 483.24 Quality of life Other residents with current Quality of life is a fundamental principle that physician orders for Ativan to applies to all care and services provided to facility residents. Each resident must receive and the be administered had the potential facility must provide the necessary care and to be affected. services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive RECEIVED assessment of a resident, the facility must ensure that residents receive treatment and care in

(k) Pain Management.

accordance with professional standards of

but not limited to the following:

practice, the comprehensive person-centered care plan, and the residents' choices, including

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

PRINTED: 04/27/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		ATE SURVEY OMPLETED
		495283	B. WING	_		0	C <b>4/20/2017</b>
	PROVIDER OR SUPPLIER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE ICHMOND, VA 23227		7720/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	provided to resider consistent with prothe comprehensive and the residents'  (I) Dialysis. The faresidents who requestrices, consister of practice, the corcare plan, and the preferences. This REQUIREME by:  Based on staff interested in the facility staff failed to maintain a reside for one of 25 resident #1.  The facility staff failed having an antianxical record in the facility staff failed to maintain a residence of the facility staff failed and the facility staff failed for one of 25 resident #1.	nsure that pain management is nts who require such services, fessional standards of practice, e person-centered care plan, goals and preferences.  cility must ensure that aire dialysis receive such not with professional standards in prehensive person-centered residents' goals and  NT is not met as evidenced erview, facility document review review, it was determined that ed to provide care and services ents' highest level of well-being ents in the survey sample,  led to administer Resident #1's pedtime dose of the medication ety medication (1)) on 4/17/17.	F3	809	Systematic Changes:  Beginning 4/20/17, audits were completed to determine compliance with medication administration of Ativan for patients with current physicia orders.  Beginning 4/20/17, licensed n were educated by the ADNS a her designee regarding the importance of adhering to physician orders related to medication administration and the Emergency Medication Supretrieval process	n urses nd/or	5/aa/r
	1/27/17. Resident were not limited to: pressure and major Resident #1's most set), a 60 day Medi (assessment refere the resident as beir documented Resident	#1's diagnoses included but anxiety disorder, high blood recent MDS (minimum data care assessment with an ARD ence date) of 3/24/17, coded and cognitively intact. Section Neent #7 received antianxiety but of the last seven days.			RECEIVED MAY 0 9 2017 VDH/OLC		

Review of Resident #1's clinical record revealed a

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

PRINTED: 04/27/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		E SURVEY MPLETED
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		495283	B. WING	·		04	/20/2017
	PROVIDER OR SUPPLIER	CES-IMPERIAL		1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			BE	(X5) COMPLETION DATE
F 309	Continued From page 8 physician's order summary signed by the physician on 4/19/17 that documented an order with a start date of 2/10/17 for Ativan 0.5 mg (milligrams) by mouth at bedtime for anxiety.		F3	309	Monitoring System:  Beginning 5/8/17, a weekly random audit of 10 resident	s	5/22/19
	Resident #1's April administration reco Ativan 0.5 mg by m	2017 MAR (medication rd) documented an order for outh at bedtime for anxiety.	with physician orders medication administra Ativan and the Emerge		with physician orders for medication administration of Ativan and the Emergency Medication retrieval process		
:	A nurse's note dated 4/17/17 at 11:41 p.m. documented, "Ativan Tablet 0.5 MG. Give 0.5 mg by mouth at bedtime for anxiety. Resident need new hardscript (prescription). Medication not given." A nurse's note signed by the same nurse				(as applicable) will be compl by the ADNS and/or her designee for compliance.		
		at 12:14 a.m. documented in m.) ativan 0.5 mg not given. new hard script"			Audits will be conducted for weeks and then monthly for		The control of the co
	medication utilization	#1's Ativan controlled on record failed to reveal the istered 0.5 mg of Ativan at	months thereafter. Identified discrepancies will be addressed accordingly ar as appropriate.			d	
:	on 2/8/17 documen effects related to: us antianxietyInterve	rehensive care plan initiated ted, "At risk for adverse se of ntions: med (medication) as administration record)"		Such will be forwarded to the QA&A Committee for further review and/or possible revisio to facility protocol.		r	
:	box (a box containing case they are needed	y controlled STAT (immediate) ng different medications in ed for administration) list lets of Ativan were available			RECEIVE	D	
	The nurse who doc	umented the above nurse's ble for interview during the			MAY 0.9 201 <b>VDH/OL</b> (		

On 4/19/17 at 10:09 a.m., an interview was

	TMENT OF HEALTH	AND HUMAN SERVICES & MEDI( ) SERVICES				FOF	ED: 04/27/2017 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	(X3) E	OATE SURVEY OMPLETED
	·	495283	B. WING			<del></del>	C <b>04/20/2017</b>
	PROVIDER OR SUPPLIER  CARE HEALTH SERVI	CES-IMPERIAL		17	TREET ADDRESS, CITY, STATE, ZIP CO 719 BELLEVUE AVENUE ICHMOND, VA 23227	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)	HOULD BE	(X5) COMPLETION DATE
F 309	LPN #2 was asked is ordered to be adr LPN #2 stated that strength or dose of medication may be narcotic STAT box. procedure for obtain STAT box. LPN #2 out and nurses had confirm the medical stated the form had to obtain a code to and typically she ve STAT box with anotafter she accesses is completed that ve pulled from the STA in the resident's characteristic states another in narcotic STAT box a pharmacy. LPN #2 facility process in plant out of Ativan. LI pharmacy is notified refills and if a new physician is notified. On 4/19/17 at 5:05 pataff member) #1 (the strength of the states of the state	N (licensed practical nurse) #2. what should be done if Ativan ministered and is not available. depending on the ordered the medication, the able to be obtained from the LPN #2 was asked the ning Ativan from the narcotic stated there was a form to fill to call the pharmacy to tion was available. LPN #2 to be faxed to the pharmacy access the narcotic STAT box rifies access to the narcotic her nurse. LPN #2 stated the narcotic STAT box, a form erifies the medication was at Dox and the form is placed art. LPN #2 stated she also form that is placed back in the and the form is returned to the was asked if there was a acce to ensure residents didn't PN #2 stated typically the I on Wednesdays regarding prescription is needed then the	F	309			
	J	ed, "MEDICATION AND			REC	EIVEC	
	TREATMENT ADMI	NISTRATION GUIDELINES"			MAY	0 9 2017	

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

according to physician orders are reported to the attending physician and documented in the clinical record including the name and dose of the

Event ID: NTIP11

Facility ID: VA0154

If continuation sheet Page 10 of 25

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# DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  DING		OMPLETED C
		495283	B. WING		_   (	04/20/2017
	PROVIDER OR SUPPLIES			STREET ADDRESS, CITY, STA 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE ) TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 309	medication and redocument the profrom the STAT box No further information (1) Ativan is used	eason" The policy failed to cess for obtaining medication	manded from the features.	309		
F 387 SS=E	https://www.ncbi.r T0010988/?report	nlm.nih.gov/pubmedhealth/PMH ≔details REQUENCY & TIMELINESS OF 「	į	587 <b>F 387</b>		<b>5</b>  33 19
	(1) The residents least once every 3 admission, and at (2) A physician visoccurs not later the visit was required. This REQUIREME by:  Based on staff into and facility document that facility staff faci	must be seen by a physician at 30 days for the first 90 days after least once every 60 thereafter. Sit is considered timely if it an 10 days after the date the ENT is not met as evidenced terview, clinical record review ent review, it was determined illed to ensure timely physician residents in the survey sample, #13, #17, and #10.  If failed to ensure that Resident physician within 60 days after t documented visit by the		On 3/30/17, a physical was completed for On 3/30/17 a physical was completed for On 5/8/17 a physical was completed for On 5/8/17 a physical was completed for On 3/24/17 a physical was completed for On 3/24	ysician visit or resident # 7. ysician visit or resident #16. sician visit or resident #13. sician visit or resident #17.	

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Facility ID: VA0154

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MAY U9 2017

	MENT OF HEALTH	AND HUMAN SERVICES & MEDI( ) SERVICES			FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	LTIPLE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING		MPLETED C
		495283	B. WING		i	/20/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	CES-IMPERIAL		1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
F 387	Continued From pa	ge 11	F3	387		
;	#13 was seen by a	failed to ensure that Resident physician within 60 days and 1/25/17 (a period of 91		Other Potential Residential Affected:	ts	5/22/17
	#17 was seen by a	failed to ensure that Resident physician within 60 days id 12/28/16 (a period of 185		Other residents who were duphysician visits had he potento to be affected.	-	TO MARKATANA CONTRACTOR AND A CONTRACTOR OF THE
		ailed to ensure that Resident physician from 10/26/16 to 47 days.		Systematic Changes:		5   22   19
	10/04/11 with diagnonot limited to demerarthritis and enlarge most recent MDS (requarterly assessme reference date) of 3 coded as being impout of 15 on the BIM Status) exam. Resi requiring extensive staff members with assistance from one and toileting; and to member with dressi hygiene, and bathing	admitted to the facility on oses that included but were ntia, stroke, retention of urine, of prostate. Resident #7's minimum data set) was a nt with an ARD (assessment /17/17. Resident #7 was aired of cognition scoring 08 dS (Brief Interview for Mental dent #7 was coded as assistance from two or more transfers; extensive e staff member with eating tal dependence on one staffing, locomotion, personal		Beginning 4/20/17, an audit of physician visits for current residents was completed for compliance with timely visit.  On 4/20/17, the Medical Reconstructor was re-educated regover the importance and guideline monitoring physician visits and documentation for timely compliance.	arding es of	
	physician visit by the	#/'s clinical record revealed a e MD (medical doctor) that . No other physician visits	•			:

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could be found after that date in the clinical

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PRINTED: 04/27/2017



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

PRINTED: 04/27/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDIĆ 🖒 SERVICES				0	<u>VIB NO.</u>	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION			SURVEY PLETED
		495283	B. WING	;			04/2	20/2017
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP COL	DE		
MANORCA	ARE HEALTH SERVI	ICES-IMPERIAL		l	719 BELLEVUE AVENUE ICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
	Continued From pa	ge 12	F;	387 :	Monitoring System:		Access to the second se	5/22/11
	On 4/19/17 at approinterview was condituded by the process to ensure stated that she audithe date of their last audits, OSM #1 stated that she doctors when he constated that one physical computer system residents with her wosm #1 stated that ensure physician viscould not find physical fer October 26th 2 wasn't sure what he'll could have missed on 4/19/17 at 4:00 staff member) #1, the facility policy tit Visits and Documer following: "It is impossible to patient or patient on the patient of patient on the patient of the process of the patient of the patient of the process	oximately 12:40 p.m., an ucted with OSM (Other Staff cal records. When asked about are physician visits, OSM #1 its residents' charts to check t physician visit. From these ted that she will create a list of d to be seen by the physician. It will give this list to one of the omes to the facility. OSM #1 sician receives her list through and she will bring the list of when she arrives to the facility. It she follows up every week to sits. OSM #1 stated that she ician visits for Resident #7 2016. OSM #1 stated that she ad happened. OSM #1 stated, ad it."  p.m., ASM (administrative he administrator, ASM f member) #2, the DON (a) and ASM #4, the Quality the nurse were made aware of the ortant that the following itored to ensure physician of documented in the electronic ints are seen by a physician dimission, every 30 days for the			Beginning 5/8/17, weekly and Audits of 10% of current rewill be completed by the Aland/or her designee for cowith monitoring physician documentation for timely and Audits will be conducted for weeks and the monthly for months thereafter.  Identified discrepancies will addressed accordingly and appropriate.  Such will be forwarded to the QA&A Committee for further review and/r possible revisito facility protocol.	esider dmin omplia visits. visits. or fou r two II be as the	nt istrator ance and	

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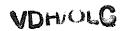
first 90 days after admission and at least once every 60 days thereafter or per state regulations. A physician visit is considered timely if it occurs

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	TMENT OF HEALTH	AND HUMAN SERVICES  & MEDIC SERVICES				FOR	D: 04/27/2017 M APPROVED O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .		CONSTRUCTION		ATE SURVEY OMPLETED
		495283	B. WING			0	4/20/2017
NAME OF	PROVIDER OR SUPPLIER	Landaria de la constanta de la			REET ADDRESS, CITY, STATE, ZIP CODI		
MANOR	CARE HEALTH SERVI	CES-IMPERIAL			9 BELLEVUE AVENUE CHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 387	or as otherwise stip regulationsProce signed and dated pl monthly physician or reviewing patients esystem2. If a requidocumented in a pridelinquent letter to the needed visit or odirector of nursing (progressive interversions)	e date the visit was required bulated by state dure: Review records for hysician progress notes, orders and telephone orders by entire record in the electronic uired physician visit is not togress note: send a the physician as notification of documentation. Notify the DON). 3. Implement notions to secure physician quirements for timely visits and rogress notes"	F	387			
	#16 was seen by a between 10/26/16 a days).  Resident #16 was a 6/22/11 with diagnostimited to End Stage neuropathy, and dia #16's most recent Massessment referent #16 was coded as becognition scoring 99 Interview for Mental	ailed to ensure that Resident physician within 60 days and 3/30/17 (a period of 155 dimitted to the facility on ses that included but were not be Renal Disease, heart failure, abetes mellitus. Resident MDS (minimum data set) was assessment with an ARD note date) of 4/2/17. Resident being severely impaired of 0 out of 15 on the BIMS (Brief Status) exam. Resident #16 ring total dependence on one					
	staff member with tr	ransfers, personal hygiene, g; and extensive assistance					: :

#### PRINTED: 04/27/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDI **SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING \_ C 495283 B. WING 04/20/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1719 BELLEVUE AVENUE** MANORCARE HEALTH SERVICES-IMPERIAL RICHMOND, VA 23227 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 387 Continued From page 14 F 387 Review of Resident #16's clinical record revealed a physician progress note from a physician's visit dated 10/26/16. The next physician visit in the clinical record was dated 3/30/17. Physician visits between 10/26/16 and 3/30/17 (155 days) could not be found in the clinical record. On 4/19/17 at approximately 12:40 p.m., an interview was conducted with OSM (Other Staff Member) #1, medical records. When asked about the process to ensure physician visits, OSM #1 stated that she audits residents' charts to check the date of their last physician visit. From these audits, OSM #1 stated that she will create a list of Residents who need to be seen by the physician. She stated that she will give this list to one of the doctors when he comes to the facility. OSM #1 stated that one physician receives her list through a computer system and she will bring the list of residents with her when she arrives to the facility. OSM #1 stated that she follows up every week to ensure physician visits. On 4/19/17 at 4:00 p.m. at the end of day meeting, Resident #16's physician visits were requested. On 4/20/17 at 8:45 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that she could not locate the physician visits for

3/30/17.

Resident #16. ASM #1 stated that medical records (OSM #1) could not locate physician visits for Resident #16 between 10/26/16 and

On 4/20/17 at 8:45 a.m., ASM #1, the administrator was made aware of the above concerns. No further information was presented

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION  ING	0	(3) DATE SURVEY COMPLETED C
		495283	B. WING			04/20/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 1719 BELLEVUE AVENUE RICHMOND, VA 23227	ZIP CODE	0112012011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		CTION SHOULD B THE APPROPRIA	
F 387	Continued From pa	age 15	F3	887		
	#13 was seen by a	failed to ensure that Resident physician within 60 days and 1/25/17 (a period of 91	Volument of the state of the st			
	11/1/14 with a read diagnoses that incl chronic kidney dise	admitted to the facility on Imission date of 10/13/15 with uded, but not limited to, ease, high blood pressure and in the blood stream.	Andrew Company of the State of			
	set) was a quarterly (assessment reference Resident #13 was of BIMS (brief interview ten out of 15. The	st recent MDS (minimum data y assessment with an ARD ence date) of 1/13/17. coded on the MDS as having a ew for mental status) score of MDS manual documents that eates that the resident's ately impaired.				
	revealed that there	nt #13's clinical record were no physician notes and 1/25/17 (a period of 91				
	was made of the ac evidence that Resid	oximately 11:30 a.m. a request dministrative staff to provide dent #13 had been seen by a the dates 10/26/16 and				
	conducted with ASI member) #1, the act that she was unable	0 p.m. an interview was M (administrative staff dministrator. ASM #1 stated e to locate any notes to dent #13 had been seen				

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<del>-</del>	TMENT OF HEALTH	AND HUMAN SERVICES & MEDI SERVICES				FORM	: 04/27/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		CONSTRUCTION	(X3) DAT COM	E SURVEY APLETED
		495283	B. WING	l			C <b>20/2017</b>
NAME OF F	PROVIDER OR SUPPLIER	,		l .	EET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-IMPERIAL			9 BELLEVUE AVENUE HMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 387	Continued From pa	ge 16	F;	387			
	· · · · · · · · · · · · · · · · · · ·	and 1/25/17. ASM #1 was					
		ponsible for ensuring that the					
	residents were seer	n timely, every 60 days. ASM					
		redical records staff member,					
	OSM (other staff me	ember) #1 was responsible.					
	On 4/19/17 at 12:45	p.m. an interview was					
		M #1, the medical records					
		en asked if she was able to		•			
		t Resident #13 had been seen		:			1
		een 10/26/16 and 1/25/17,					
,		there were no visits. OSM #1 ibe her process to ensure that					:
		by a physician in a timely			,		
		tated, "I audit the records and					:
		list of patients and highlight					
		ysician must see at the next					
		s office has had a staffing					
		ocess has changed, I can no					
		st electronically to their office."					:
		ed, "I am not sure what					
	happened to these	/ISIIS.					
	On 4/19/17 at 4:00 r	o.m. an end of day meeting					
		#1, the administrator, ASM					
		ursing and ASM #4, the					
		pordinator. The administrative					
		re of the above findings at					
	this time.						
	No fuetbos informatio	on was provided prior to the					:
	end of the survey pr						
	ora or the adivey pr						,
		· · · · · · · · · · · · · · · · · · ·					
	4. The facility staff	failed to ensure that Resident					
	#17 was seen by a p	physician within 60 days				;	:
	between 6/16/16 and days).	d 12/28/16 (a period of 185					

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

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495283	B. WING		04	C J <b>/20/2017</b>
	PROVIDER OR SUPPLIE	ER	1	STREET ADDRESS, CITY, STATE, ZII 1719 BELLEVUE AVENUE RICHMOND, VA 23227		120/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 387	8/24/01 with a readiagnoses that in multiple sclerosis system eats awarnerves), depressions Resident #17's moset) was a quarte (assessment reference Resident #17 was BIMS (brief interval in the out of 15. The ascore of nine in cognition is model.	is admitted to the facility on admission date of 8/11/15 with included, but not limited to, is (A disease in which the immune by at the protective covering of sion and a low functioning thyroid.  In ost recent MDS (minimum data arry assessment with an ARD erence date) of 1/22/17. Its coded on the MDS as having a view for mental status) score of the MDS manual documents that indicates that the resident's erately impaired.	F 3	87		
	revealed that the	dent #17's clinical record re were no physician notes and 12/28/16, a period of 185	**************************************			
	conducted with O staff member. O	:45 p.m. an interview was OSM #1, the medical records OSM #1 was asked how ysician was to visit a resident, every 60 days.	min in the property of the control o			
	4:00 p.m. with AS #1, the administra nursing and ASM coordinator. The aware that there clinical record that seen by a physici 12/28/16. ASM #	day meeting held on 4/19/17 at SM (administrative staff member) ator, ASM #2, the director of 1 #4, the quality assurance administrative staff was made was no evidence found in the at showed that Resident #17 was ian between 6/16/16 and #1 stated that she would look into rould provide this surveyor with ext morning.	TOTAL CONTINUES OF THE PROPERTY OF THE PROPERT			

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		AND HUMAN SERVICES & MEDIC SERVICES			FC	ED: 04/27/2017 PRM APPROVED NO. 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3)	DATE SURVEY COMPLETED
		495283	B. WING _			04/20/2017
NAME OF	PROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE,	ZIP CODE	
MANOR	CARE HEALTH SERVI	CES-IMPERIAL		1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 387	whether or not she evidence that Resic physician between that ASM #1 stated that that she did not thin documentation.  On 4/20/17 at 8:45 surveyor, "We were (physician notes) for that would indicate been seen by a phy 12/28/16.  No further information end of the survey process. The facility staff of #10 was seen by a 3/24/17, a total of 1/2 Resident #10 was a 12/14/14 with diagn not limited to, high to cholesterol, dement obstructive pulmona arthritis.  Resident #10's moset) was a quarterly (assessment reference.	a.m. ASM #1 was asked had been able to locate lent #17 had been seen by a the aforementioned dates, she would double check and k that she had any  a.m. ASM #1 stated to this not able to find any notes r this resident (Resident #17) that she (Resident #17) had sician between 6/16/16 and on was provided prior to the rocess.  ailed to ensure that Resident physician from 10/26/16 to 47 days.	F 38'	7:		

by others and usually able to understand others.
Resident # 10 was coded as scoring a 15 of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating

the resident was cognitively intact.

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

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	10 1 OIL MEDIOLIKE	- CINEDIC PORTITIOES			· · · · · · · · · · · · · · · · · · ·		***************************************	<del></del>
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION			E SURVEY MPLETED
								С
		495283	B. WING				. 04	/20/2017
	PROVIDER OR SUPPLIER  CARE HEALTH SERV	ICES-IMPERIAL		171	REET ADDRESS, CITY, STATE, ZIP CO 9 BELLEVUE AVENUE CHMOND, VA 23227	)DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 387	revealed progress and 3/24/17, a total	age 19 nt #10's clinical record notes that were dated 10/26/16 of 147 days between notes. notes were provided.	F 3	87 ·				Transfer of the state of the st
	ASM (administrative administrator, this construction request was made that could be found 3/24/17. ASM # 1 member was responsely a significant visits. As a significant visits.	on 4/19/17 at 12:35 p.m. with e staff member) # 1, the concern was revealed and a for any other physician notes between 10/26/16 and was also asked which staff insible for keeping track of 6M #1 stated that it was [name member) # 1, the medical per].						
	OSM # 1, OSM # 1 is to keep track of p stated that when the building she (OSM of the Residents that To get the list she (residents' charts to visit was made and OSM # 1 continued the residents' charts ups with the physician with the physician. Some of the their office that this was a big of (OSM #1) could just access to the notes (notes) into the Residents of physician.	on 4/19/17 at 12:38 p.m. with was asked what the process physician visits; OSM # 1 to physician comes into the # 1) gives each physician a list at the physician needs to see. OSM # 1) checks the see when the last physician then she makes up the list. To say that she does audits of a weekly and then she follow ans every time she does the a list for each physician and the (resident's) charts for each fithe physicians write their and she (OSM # 1) stated thange. At one time she to go into the computer and get print them, and put them ident's charts. She can no has to depend on the						

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OSM # 1 was then asked to review Resident #

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY MPLETED
		495283	B. WING	_		1	C /20/2017
• • • • • • • • • • • • • • • • • • • •	PROVIDER OR SUPPLIE	R	<u> </u>	17	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE ICHMOND, VA 23227	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 387	During an intervie OSM # 1, OSM # locate any other of visited Resident # 3/24/17. During the end of p.m. with ASM #1 the director of nur	e if she could locate any visits	F				
	end of the survey 483.70(i)(1)(5) RI RECORDS-COM LE  (i) Medical record (1) In accordance standards and promaintain medical are-  (i) Complete;  (ii) Accurately documents of the survey	PLETE/ACCURATE/ACCESSIB s. with accepted professional actices, the facility must records on each resident that cumented; sible; and	F	514	Corrective Action:  On 4/20/17, the dictated pronotes for resident #13 and #5 obtained from the MD office filed in the facility medical resident Affected:  Other Potential Resident Affected:  Other residents who had dict progress notes had the potential be affected.	were and cord.	5/a>lm

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION		E SURVEY IPLETED
				NG _		1	С
		495283	B. WING			04/	20/2017
	PROVIDER OR SUPPLIER  CARE HEALTH SER			17	REET ADDRESS, CITY, STATE, ZIP CODE 119 BELLEVUE AVENUE ICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	**************************************	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	. <b>`</b>	age 21 nation to identify the resident; resident's assessments;	F 5	14	Systematic Changes:		5  <i>3</i>  17
	(iii) The comprehe provided; (iv) The results of and resident review	nsive plan of care and services any preadmission screening			Beginning 4/20/17, an audit of current resident medical records Was completed for compliance with filing dictated physician progress notes.		
	professional's prog (vi) Laboratory, rac services reports as This REQUIREME by: Based on staff into and clinical record the facility staff fail accurate clinical re	diology and other diagnostic is required under §483.50. INT is not met as evidenced erview, facility document review review, it was determined that ed to maintain a complete and ecord for two of 25 residents in			On 4/20/17, the Medical Record Director was re-educated regard the importance of maintain a color and medical record and the requand guidelines for clinical record	ding mplete uireme	nts
	<ol> <li>#5.</li> <li>The facility staff dictated physician with Resident #13</li> <li>The facility staff dictated physician with Resident #5 or The findings included.</li> <li>The facility staff dictated physician</li> </ol>	f failed to obtain and file notes for visits that occurred on 4/20/16 and 6/29/16.  If failed to obtain and file notes for visits that occurred n 8/5/16 and 10/7/16.  Ite: If failed to obtain and file notes for visits that occurred on 4/20/16 and 6/29/16.			Monitoring System:  Beginning 5/8/17, a weekly rand audit of 10% of current resident medical records will be complet by the Administrator and/or her designee for compliance with filing dictated physician progress. Audits will be conducted for fou weeks and then monthly for two months thereafter.	: ed - s notes r	5 22 17

Event ID: NTIP11

Facility ID: VA0154

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

PRINTED: 04/27/2017 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		OATE SURVEY COMPLETED
		495283	B. WING			C 04/20/2017
	PROVIDER OR SUPPLIE CARE HEALTH SER			STREET ADDRESS, CITY, STATE, ZIP CO 1719 BELLEVUE AVENUE RICHMOND, VA 23227	~~~~	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 514	11/1/14 with a readiagnoses that incorronic kidney dishigh levels of lipid Resident #13's maset) was a quarter (assessment references and the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out of 15. The ascore of ten indicognition is modern as the first ten out	admitted to the facility on dmission date of 10/13/15 with cluded, but are not limited to: lease, high blood pressure and in the blood stream.  Ost recent MDS (minimum datally assessment with an ARD rence date) of 1/13/17. It coded on the MDS as having a lew for mental status) score of the MDS manual documents that cates that the resident's	F 5	Identified discrepancies addressed accordingly a appropriate.  Such will be forwarded to QA&A Committee for fureview and/or possible ratio facility protocol.	nd as to the rther	5/22/17
	conducted with AS member) #1, the a that she was unable evidence that Res between 2/17/16 a who was responsi residents were see #1 stated that the	40 p.m. an interview was SM (administrative staff administrator. ASM #1 stated let to locate any notes to ident #13 had been seen and 7/5/16. ASM #1 was asked ble for ensuring that the en timely, every 60 days. ASM medical records staff member, nember) #1 was responsible.				

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

Event ID: NTIP11

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CENTER		AND HUNN SERVICES  & MEDIC D SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII	TIPI F	CONSTRUCTION	FOR OMB NO	D: 04/27/2017 M APPROVED O. 0938-0391 ATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '			cc	OMPLETED
		495283	B. WING				4/20/2017
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL	A COMPANY AND A	171	REET ADDRESS, CITY, STATE, ZIP CODE 9 BELLEVUE AVENUE CHMOND, VA 23227	į	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 23	F 5	514			
	conducted with OSi staff member. Whe locate evidence that by a physician betw #1 stated that she hidicated notes from asked if the notes w OSM #1 stated that asked to describe himsident clinical reconductions.	5 p.m. an interview was M #1, the medical records en asked if she was able to t Resident #13 had been seen reen 2/17/16 and 7/5/16, OSM and just received copies of the the physician's office. When were in the clinical record, they were not. OSM #1 was her process to ensure that the ords were complete; OSM #1 ducted a weekly audit of the					
	was held with the a administrative staff findings at this time	p.m. an end of day meeting dministrative staff. The was made aware of the above . A policy on maintaining a rate clinical record was ne.					
	Guidelines for Clinic in part, the following record is compiled a document containin patient, justify the d document results at patient throughout t admission to dischadocumentation is at quality assessment Physician Visits and reports are transcrit of dictation and transcript in part of the company of th	led, "Requirements and cal Record Content" revealed, g documentation; "A clinical as a confidential medical legal g sufficient data to identify the iagnosis and treatment, and reflect the condition of the he stay in the center from arge. Review of clinical record a important aspect of the and assurance process. I Progress Notes: Dictated bed, indicating both the dates ascription and filed in the a seven (7) days of dictation.					

General Guidelines: Clinical records are maintained on each patient that are complete,

		AND HUMAN SERVICES				FORM	: 04/27/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COM	E SURVEY PLETED
		495283	B. WING	;			20/2017
	PROVIDER OR SUPPLIER  CARE HEALTH SERVI	CES-IMPERIAL		171	REET ADDRESS, CITY, STATE, ZIP CODE  19 BELLEVUE AVENUE  CHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 514	Documentation in the	ge 24 and systematically organized. he clinical record is expected accurately reflect each	F	514			
	No further informati end of the survey pr	ion was provided prior to the rocess.					
	•						
			Application of the control of the co				
							:
							! :
							:

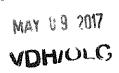
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NTIP11

Facility ID: VA0154

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State of \	√irginia						
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLII		1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	<b>.</b>	B. WING _		04/2	20/2017
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STREET AD	DRESS, CITY,	STATE, ZIP CODE		****
MANORO	ARE HEALTH SERVI	ICES-IMPERIAL	1	LEVUE AVE ID, VA 2322			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
F 000	Initial Comments		•	F 000			
	Inspection was cor 4/23/15. Correctio with the following w	piennial State Licenson Inducted 4/21/15 through Ins are required for continuity with the Virginia Rule of Licensure of Nursin	ugh ompliance s and		Cross Reference		5/26
The census in this 128 certified bed 113 at the time of the survey. The s consisted of 20 current Resident re (Residents 1 through 20) and 5 clos reviews (Residents 21 through 25).		he survey. The surv irrent Resident reviev gh 20) and 5 closed	ey sample ws		12VAC5-371-240A Residual cross reference to F278		nent
F 001	Non Compliance	5 2 1 (1110ugii 23).		F 001	12VAC5-371-220B Nurs cross reference to F309	ing Services	to
	The facility was out of compliance with the following state licensure requirements:				12VAC5-371-140 Policies and Procedures cross reference to F387 and F514		
recycle to Attack hamman and the second	F278 cross referen	is RULE: is not met as evidenced by: 78 cross reference to 12VAC5-371-240A sident assessment			12VAC5-371-240 Physic cross reference to F387	an Services	to
11 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	Nursing Services F387 and F514 are	cross references to 12 VAC 5 - 371 220 B Services and F514 are cross referenced to 5-371-140 Policies and Procedures			Date of compliance is 5/	'22/17.	
	F387 cross Refere Physician services.	ence to 12VAC5-371-	-240		RECEIV	'ED	
-			: :		MAY 09 2	017	
!			:		ADHAOF	.C	:
:		DER/SUPPLIER REPRESEN			TITLE		(X6) DATE

021199

STATE FORM

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