STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-IMPERIAL	1719 BELLEVUE AVENUE RICHMOND, VA 23227

(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	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 4/18/17 through 4/20/17. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 128 certified bed facility was 113 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents 1 through 20) and 5 closed record reviews (Residents 21 through 25).

F 278 SS=D 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED — F 278

(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

(h) Coordination
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(i) Certification
(1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for Falsification
(1) Under Medicare and Medicaid, an individual who willfully and knowingly-

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
M. Arnold, Adm.		5/8/17

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.

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F 278	Continued From page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to complete an accurate MDS (minimum data set) assessment for one of 25 residents in the survey sample, Resident # 3. The facility staff failed to accurately document the correct date of Resident # 3's influenza vaccination on the quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/22/17. The findings include: Resident # 3 was admitted to the facility on 10/18/16 with diagnoses that included but not limited to: Parkinson's disease (1), dysphagia (2), diabetes mellitus (3), gastroesophageal reflux disease (4), depression, glaucoma (5) and chronic kidney disease (6). The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/22/17 coded Resident # 3 as scoring a 15 on the brief interview for mental	F 278	**F 278** **Corrective Action:** 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. **Other Potential Residents Affected:** Other residents who require Section O of an MDS assessment to be completed had the potential to be affected.	5/22/17 5/22/17

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F 278	Continued From page 2 status (BIMS) of a score of 0 - 15, 15 being cognitively intact for daily decision making. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living. Section B0700 "Makes Self Understood" coded Resident # 3 as "Understood" and section B0800 "Able To Understand Others" coded Resident # 3 as "Understands - clear comprehension." Section O0250 "Influenza Vaccination" coded Resident # 3 a "0 (zero). No. - Skip to O0250C, If influenza vaccine not received, state reason." Under section O0250C Individual # 3 was coded "9 (nine). None of the above." Review of Resident # 3's electronic clinical record revealed the eMAR (electronic medication administration record) dated November 2017. The eMAR documented, "Flu (influenza) 0.5 ml (milliliter) one time only for the flu vaccine 11/11/2016." Further review of the eMAR revealed the flu vaccine was administered on 11/11/16 at 4:34 p.m. On 04/19/17 at 10:25 a.m. an interview was conducted with RN (registered nurse) # 6, a MDS coordinator. RN # 6 was asked to review Section O0250 "Influenza Vaccination" of Resident # 3's quarterly MDS with the ARD of 01/22/17 and the "Immunization Record" for Resident # 3. When asked about the discrepancy between the MDS and the immunization record for Resident # 3, RN #6 stated, "The flu is not coded correctly." When asked what reference is used for completing the MDS RN # 6 stated she uses the RAI (Resident Assessment Instrument) manual. The RAI (Resident Assessment Instrument) manual documented, " O0250: Influenza Vaccine.	F 278	**Systematic Changes:** Beginning 4/19/17, an audit of Section O was completed for coding accuracy for current residents who require MDS assessments with discrepancies noted and/or corrected as applicable and appropriate per RAI guidelines. Beginning 4/20/17, staff who complete MDS assessments were re-educated by the Regional case mix Specialist regarding the importance of completing Section O accurately per the RAI guidelines.	5/22/17

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F 278	Continued From page 3 Steps for Assessment 1. Review the resident's medical record to determine whether an influenza vaccine was received in the facility for this year's influenza vaccination season. If vaccination status is unknown, proceed to the next step. 2. Ask the resident if he or she received an influenza vaccine outside of the facility for this year's influenza vaccination season. If vaccination status is still unknown, proceed to the next step. 3. If the resident is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If influenza vaccination status is still unknown, proceed to the next step. 4. If influenza vaccination status cannot be determined, administer the influenza vaccine to the resident according to standards of clinical practice. Coding Instructions for O0250A, Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? Code 0, no: if the resident did NOT receive the influenza vaccine in this facility during this year's influenza vaccination season. Proceed to If influenza vaccine not received state reason (O0250C). o Code 1, yes: if the resident did receive the influenza vaccine in this facility during this year's influenza season. Continue to Date influenza vaccine received (O0250B). Coding Instructions for O0250B, Date influenza vaccine received 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 01-17-2014.	F 278	**Monitoring System:** Beginning 5/8/17, a weekly random audit of 10 MDS assessments will be reviewed for accuracy validation by the Administrator and/or her designee for compliance per the RAI guidelines. Audits will be conducted for four weeks and then monthly for two months thereafter. Identified discrepancies will be addressed accordingly and/or as appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol. RECEIVED MAY 09 2017 VDH/OLC	5/22/17

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- 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 without fever, and/or history of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination.

o Code 4, Offered and declined: resident or responsible party/legal guardian has been informed of the risks and benefits of receiving the influenza vaccine and chooses not to accept vaccination.

o Code 5, Not offered: resident or responsible

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party/legal guardian not offered the influenza vaccine.
o Code 6, Inability to obtain influenza vaccine due to a declared shortage: vaccine is unavailable at this facility due to a declared influenza vaccine shortage.
o Code 9, None of the above: if none of the listed reasons describe why the influenza vaccine was not administered. This code is also used if the answer."

On 04/19/17 at 4:00 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing, were made aware of the findings.

No further information was obtained prior to exit.

References:

(1) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

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

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F 278	Continued From page 6 https://www.nlm.nih.gov/medlineplus/gerd.html. (5) A group of diseases that can damage the eye's optic nerve. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/glaucoma.html. (6) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/chronickidneydisease.html.	F 278	**F 309** **Corrective Action:** On 4/18/17, the MD for resident #1 was notified of a medication (Ativan) omission with no new orders given.	5/22/17
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and 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 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management.	F 309	**Other Potential Residents Affected:** Other residents with current physician orders for Ativan to be administered had the potential to be affected.	5/22/17

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F 309	Continued From page 7 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 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 provide care and services to maintain a residents' highest level of well-being for one of 25 residents in the survey sample, Resident #1. The facility staff failed to administer Resident #1's physician ordered bedtime dose of the medication Ativan (an antianxiety medication (1)) on 4/17/17. The findings include: Resident #1 was admitted to the facility on 1/27/17. Resident #1's diagnoses included but were not limited to: anxiety disorder, high blood pressure and major depressive disorder. Resident #1's most recent MDS (minimum data set), a 60 day Medicare assessment with an ARD (assessment reference date) of 3/24/17, coded the resident as being cognitively intact. Section N documented Resident #7 received antianxiety medication seven out of the last seven days. Review of Resident #1's clinical record revealed a	F 309	**Systematic Changes:** Beginning 4/20/17, audits were completed to determine compliance with medication administration of Ativan for patients with current physician orders. Beginning 4/20/17, licensed nurses were educated by the ADNS and/or her designee regarding the importance of adhering to physician orders related to medication administration and the Emergency Medication Supply retrieval process RECEIVED MAY 09 2017 VDH/OLC	5/22/17

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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. Resident #1's April 2017 MAR (medication administration record) documented an order for Ativan 0.5 mg by mouth at bedtime for anxiety. 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 and dated 4/18/17 at 12:14 a.m. documented in part, "2100 (9:00 p.m.) ativan 0.5 mg not given. Resident need (sic) new hard script..." Review of Resident #1's Ativan controlled medication utilization record failed to reveal the resident was administered 0.5 mg of Ativan at bedtime on 4/17/17. Resident #1's comprehensive care plan initiated on 2/8/17 documented, "At risk for adverse effects related to: use of antianxiety...Interventions: med (medication) as on mar (medication administration record)..." Review of the facility controlled STAT (immediate) box (a box containing different medications in case they are needed for administration) list revealed 0.5 mg tablets of Ativan were available in the facility. The nurse who documented the above nurse's notes was unavailable for interview during the survey. On 4/19/17 at 10:09 a.m., an interview was	F 309	**Monitoring System:** Beginning 5/8/17, a weekly random audit of 10 residents with physician orders for medication administration of Ativan and the Emergency Medication retrieval process (as applicable) will be completed by the ADNS and/or her designee for compliance. Audits will be conducted for four weeks and then monthly for two months thereafter. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol. RECEIVED MAY 09 2017 VDH/OLC	5/22/17

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conducted with LPN (licensed practical nurse) #2. LPN #2 was asked what should be done if Ativan is ordered to be administered and is not available. LPN #2 stated that depending on the ordered strength or dose of the medication, the medication may be able to be obtained from the narcotic STAT box. LPN #2 was asked the procedure for obtaining Ativan from the narcotic STAT box. LPN #2 stated there was a form to fill out and nurses had to call the pharmacy to confirm the medication was available. LPN #2 stated the form had to be faxed to the pharmacy to obtain a code to access the narcotic STAT box and typically she verifies access to the narcotic STAT box with another nurse. LPN #2 stated after she accesses the narcotic STAT box, a form is completed that verifies the medication was pulled from the STAT box and the form is placed in the resident's chart. LPN #2 stated she also completes another form that is placed back in the narcotic STAT box and the form is returned to the pharmacy. LPN #2 was asked if there was a facility process in place to ensure residents didn't run out of Ativan. LPN #2 stated typically the pharmacy is notified on Wednesdays regarding refills and if a new prescription is needed then the physician is notified.

On 4/19/17 at 5:05 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "MEDICATION AND TREATMENT ADMINISTRATION GUIDELINES" documented, "Medications not administered according to physician orders are reported to the attending physician and documented in the clinical record including the name and dose of the

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F 309	Continued From page 10 medication and reason..." The policy failed to document the process for obtaining medication from the STAT box. No further information was presented prior to exit. (1) Ativan is used to treat anxiety. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details	F 309		
F 387 SS=E	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to ensure timely physician visits for five of 25 residents in the survey sample, Resident #7, #16, #13, #17, and #10. 1. The facility staff failed to ensure that Resident #7 was seen by a physician within 60 days after 10/26/16. The last documented visit by the physician was on 10/26/17. 2. The facility staff failed to ensure that Resident #16 was seen by a physician within 60 days between 10/26/16 and 3/30/17 (a period of 155	F 387	**F 387** 5/22/17 **Corrective Action:** On 3/30/17, a physician visit was completed for resident # 7. On 3/30/17 a physician visit was completed for resident #16. On 5/8/17 a physician visit was completed for resident #13. On 5/8/17 a physician visit was completed for resident #17. On 3/24/17 a physician visit was completed for resident #10.	

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days).

3. The facility staff failed to ensure that Resident #13 was seen by a physician within 60 days between 10/26/16 and 1/25/17 (a period of 91 days).

4. The facility staff failed to ensure that Resident #17 was seen by a physician within 60 days between 6/16/16 and 12/28/16 (a period of 185 days).

5. The facility staff failed to ensure that Resident # 10 was seen by a physician from 10/26/16 to 3/24/17, a total of 147 days.

The findings include:

1. Resident #7 was admitted to the facility on 10/04/11 with diagnoses that included but were not limited to dementia, stroke, retention of urine, arthritis and enlarged prostate. Resident #7's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/17/17. Resident #7 was coded as being impaired of cognition scoring 08 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #7 was coded as requiring extensive assistance from two or more staff members with transfers; extensive assistance from one staff member with eating and toileting; and total dependence on one staff member with dressing, locomotion, personal hygiene, and bathing.

Review of Resident #7's clinical record revealed a physician visit by the MD (medical doctor) that was dated 10/26/16. No other physician visits could be found after that date in the clinical

Other Potential Residents Affected: 5/22/17

Other residents who were due physician visits had he potential to be affected.

Systematic Changes: 5/22/17

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 Records Director was re-educated regarding The importance and guidelines of monitoring physician visits and documentation for timely compliance.

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F 387	Continued From page 12	F 387	**Monitoring System:**	5/22/17

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. OSM #1 stated that she could not find physician visits for Resident #7 after October 26th 2016. OSM #1 stated that she wasn't sure what had happened. OSM #1 stated, "I could have missed it."

On 4/19/17 at 4:00 p.m., ASM (administrative staff member) #1, the administrator, ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #4, the Quality Assurance Corporate nurse were made aware of the above findings.

The facility policy titled, "Monitoring Physician Visits and Documentation" documents in part, the following: "It is important that the following guidelines are monitored to ensure physician visits are timely and documented in the electronic health record: patients are seen by a physician within 30 days of admission, every 30 days for the 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

Beginning 5/8/17, weekly random Audits of 10% of current resident will be completed by the Administrator and/or her designee for compliance with monitoring physician visits and documentation for timely visits.

Audits will be conducted for four weeks and the monthly for two months thereafter.

Identified discrepancies will be addressed accordingly and as appropriate.

Such will be forwarded to the QA&A Committee for further review and/r possible revisions to facility protocol.

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within 10 days of the date the visit was required or as otherwise stipulated by state regulations....Procedure: Review records for signed and dated physician progress notes, monthly physician orders and telephone orders by reviewing patients entire record in the electronic system...2. If a required physician visit is not documented in a progress note: send a delinquent letter to the physician as notification of the needed visit or documentation. Notify the director of nursing (DON). 3. Implement progressive interventions to secure physician compliance with requirements for timely visits and documentation of progress notes..."

No further information was provided by completion of the survey.

2. The facility staff failed to ensure that Resident #16 was seen by a physician within 60 days between 10/26/16 and 3/30/17 (a period of 155 days).

Resident #16 was admitted to the facility on 6/22/11 with diagnoses that included but were not limited to End Stage Renal Disease, heart failure, neuropathy, and diabetes mellitus. Resident #16's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 4/2/17. Resident #16 was coded as being severely impaired of cognition scoring 99 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #16 was coded as requiring total dependence on one staff member with transfers, personal hygiene, toileting, and bathing; and extensive assistance with one staff member with meals.

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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 Resident #16. ASM #1 stated that medical records (OSM #1) could not locate physician visits for Resident #16 between 10/26/16 and 3/30/17.

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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prior to exit.

3. The facility staff failed to ensure that Resident #13 was seen by a physician within 60 days between 10/26/16 and 1/25/17 (a period of 91 days).

Resident #13 was admitted to the facility on 11/1/14 with a readmission date of 10/13/15 with diagnoses that included, but not limited to, chronic kidney disease, high blood pressure and high levels of lipids in the blood stream.

Resident #13's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/13/17. Resident #13 was coded on the MDS as having a BIMS (brief interview for mental status) score of ten out of 15. The MDS manual documents that a score of ten indicates that the resident's cognition is moderately impaired.

A review of Resident #13's clinical record revealed that there were no physician notes between 10/26/16 and 1/25/17 (a period of 91 days).

On 4/19/17 at approximately 11:30 a.m. a request was made of the administrative staff to provide evidence that Resident #13 had been seen by a physician between the dates 10/26/16 and 1/25/17.

On 4/19/17 at 12:40 p.m. an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that she was unable to locate any notes to evidence that Resident #13 had been seen

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between 10/26/116 and 1/25/17. ASM #1 was asked who was responsible for ensuring that the residents were seen timely, every 60 days. ASM #1 stated that the medical records staff member, OSM (other staff member) #1 was responsible.

On 4/19/17 at 12:45 p.m. an interview was conducted with OSM #1, the medical records staff member. When asked if she was able to locate evidence that Resident #13 had been seen by a physician between 10/26/16 and 1/25/17, OSM #1 stated that there were no visits. OSM #1 was asked to describe her process to ensure that residents were seen by a physician in a timely manner. OSM #1 stated, "I audit the records and give the physician a list of patients and highlight the ones that the physician must see at the next visit. The physician's office has had a staffing change and their process has changed, I can no longer submit this list electronically to their office." OSM #1 further stated, "I am not sure what happened to these visits."

On 4/19/17 at 4:00 p.m. an end of day meeting was held with ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the quality assurance coordinator. The administrative staff was made aware of the above findings at this time.

No further information was provided prior to the end of the survey process.

4. The facility staff failed to ensure that Resident #17 was seen by a physician within 60 days between 6/16/16 and 12/28/16 (a period of 185 days).

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Resident #17 was admitted to the facility on 8/24/01 with a readmission date of 8/11/15 with diagnoses that included, but not limited to, multiple sclerosis (A disease in which the immune system eats away at the protective covering of nerves), depression and a low functioning thyroid.

Resident #17's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/22/17. Resident #17 was coded on the MDS as having a BIMS (brief interview for mental status) score of nine out of 15. The MDS manual documents that a score of nine indicates that the resident's cognition is moderately impaired.

A review of Resident #17's clinical record revealed that there were no physician notes between 6/16/16 and 12/28/16, a period of 185 days.

On 4/19/17 at 12:45 p.m. an interview was conducted with OSM #1, the medical records staff member. OSM #1 was asked how frequently the physician was to visit a resident, OSM #1 stated every 60 days.

During an end of day meeting held on 4/19/17 at 4:00 p.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the quality assurance coordinator. The administrative staff was made aware that there was no evidence found in the clinical record that showed that Resident #17 was seen by a physician between 6/16/16 and 12/28/16. ASM #1 stated that she would look into the matter and would provide this surveyor with information the next morning.

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On 4/20/17 at 8:25 a.m. ASM #1 was asked whether or not she had been able to locate evidence that Resident #17 had been seen by a physician between the aforementioned dates. ASM #1 stated that she would double check and that she did not think that she had any documentation.

On 4/20/17 at 8:45 a.m. ASM #1 stated to this surveyor, "We were not able to find any notes (physician notes) for this resident (Resident #17) that would indicate that she (Resident #17) had been seen by a physician between 6/16/16 and 12/28/16.

No further information was provided prior to the end of the survey process.

5. The facility staff failed to ensure that Resident # 10 was seen by a physician from 10/26/16 to 3/24/17, a total of 147 days.

Resident # 10 was admitted to the facility on 12/14/14 with diagnoses that included, but were not limited to, high blood pressure, high cholesterol, dementia, depression, chronic obstructive pulmonary disease, convulsions, and arthritis.

Resident # 10's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/17/17. Resident # 10 was coded as usually understood 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.

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A review of Resident #10's clinical record revealed progress notes that were dated 10/26/16 and 3/24/17, a total of 147 days between notes. No other physician notes were provided.

During an interview on 4/19/17 at 12:35 p.m. with ASM (administrative staff member) # 1, the administrator, this concern was revealed and a request was made for any other physician notes that could be found between 10/26/16 and 3/24/17. ASM # 1 was also asked which staff member was responsible for keeping track of physician visits. ASM #1 stated that it was [name of OSM (other staff member) # 1, the medical records staff member].

During an interview on 4/19/17 at 12:38 p.m. with OSM # 1, OSM # 1 was asked what the process is to keep track of physician visits; OSM # 1 stated that when the physician comes into the building she (OSM # 1) gives each physician a list of the Residents that the physician needs to see. To get the list she (OSM # 1) checks the residents' charts to see when the last physician visit was made and then she makes up the list. OSM # 1 continued to say that she does audits of the residents' charts weekly and then she follow ups with the physicians every time she does the audit. She makes a list for each physician and she then pulls out the (resident's) charts for each physician. Some of the physicians write their notes at their office and she (OSM # 1) stated that this was a big change. At one time she (OSM #1) could just go into the computer and get access to the notes, print them, and put them (notes) into the Resident's charts. She can no longer do that and has to depend on the physician's office to send the notes to the facility. OSM # 1 was then asked to review Resident #

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F 387	Continued From page 20 10's record to see if she could locate any visits between 10/26/16 and 3/24/17. During an interview on 4/19/17 at 1:20 p.m. with OSM # 1, OSM # 1 stated that she could not locate any other documentation that a physician visited Resident # 10 between 10/26/16 and 3/24/17. During the end of day interview on 4/19/17 at 4:00 p.m. with ASM #1, the administrator, ASM # 2, the director of nurses, and ASM # 4, the corporate nurse, this concern was again reviewed. No further information was provided prior to the end of the survey process.	F 387		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain-	F 514	**F 514** **Corrective Action:** On 4/20/17, the dictated progress notes for resident #13 and #5 were obtained from the MD office and filed in the facility medical record. **Other Potential Residents Affected:** Other residents who had dictated progress notes had the potential to be affected.	5/22/17

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F 514	Continued From page 21 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of 25 residents in the survey sample, Resident #13 and Resident #5. 1. The facility staff failed to obtain and file dictated physician notes for visits that occurred with Resident #13 on 4/20/16 and 6/29/16. 2. The facility staff failed to obtain and file dictated physician notes for visits that occurred with Resident #5 on 8/5/16 and 10/7/16. The findings include: 1. The facility staff failed to obtain and file dictated physician notes for visits that occurred with Resident #13 on 4/20/16 and 6/29/16.	F 514	**Systematic Changes:** Beginning 4/20/17, an audit of current resident medical records Was completed for compliance with filing dictated physician progress notes. On 4/20/17, the Medical Records Director was re-educated regarding the importance of maintain a complete and medical record and the requirements and guidelines for clinical record content. **Monitoring System:** Beginning 5/8/17, a weekly random audit of 10% of current resident medical records will be completed by the Administrator and/or her designee for compliance with filing dictated physician progress notes. Audits will be conducted for four weeks and then monthly for two months thereafter.	5/22/17 5/22/17

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F 514	Continued From page 22 Resident #13 was admitted to the facility on 11/1/14 with a readmission date of 10/13/15 with diagnoses that included, but are not limited to: chronic kidney disease, high blood pressure and high levels of lipids in the blood stream. Resident #13's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/13/17. Resident #13 was coded on the MDS as having a BIMS (brief interview for mental status) score of ten out of 15. The MDS manual documents that a score of ten indicates that the resident's cognition is moderately impaired. A review of Resident #13's clinical record revealed that there were no physician notes filed in Resident #13's clinical record between 2/17/16 and 7/5/16. On 4/19/17 at approximately 11:30 a.m. a request was made of the administrative staff (ASM [administrative staff member] #1, the administrator, ASM #2, the director of nursing and ASM #4, the quality assurance coordinator) to provide evidence that Resident #13 had been seen by a physician between the dates 2/17/16 and 7/5/16. On 4/19/17 at 12:40 p.m. an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that she was unable to locate any notes to evidence that Resident #13 had been seen between 2/17/16 and 7/5/16. ASM #1 was asked who was responsible for ensuring that the residents were seen timely, every 60 days. ASM #1 stated that the medical records staff member, OSM (other staff member) #1 was responsible.	F 514	Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol.	5/22/17

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On 4/19/17 at 12:45 p.m. an interview was conducted with OSM #1, the medical records staff member. When asked if she was able to locate evidence that Resident #13 had been seen by a physician between 2/17/16 and 7/5/16, OSM #1 stated that she had just received copies of the dictated notes from the physician's office. When asked if the notes were in the clinical record, OSM #1 stated that they were not. OSM #1 was asked to describe her process to ensure that the resident clinical records were complete; OSM #1 stated that she conducted a weekly audit of the charts.

On 4/19/17 at 4:00 p.m. an end of day meeting was held with the administrative staff. The administrative staff was made aware of the above findings at this time. A policy on maintaining a complete and accurate clinical record was requested at this time.

The facility policy titled, "Requirements and Guidelines for Clinical Record Content" revealed, in part, the following documentation; "A clinical record is compiled as a confidential medical legal document containing sufficient data to identify the patient, justify the diagnosis and treatment, document results and reflect the condition of the patient throughout the stay in the center from admission to discharge. Review of clinical record documentation is an important aspect of the quality assessment and assurance process. Physician Visits and Progress Notes: Dictated reports are transcribed, indicating both the dates of dictation and transcription and filed in the clinical record within seven (7) days of dictation. General Guidelines: Clinical records are maintained on each patient that are complete,

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F 514	Continued From page 24 readily accessible and systematically organized. Documentation in the clinical record is expected to be timely and to accurately reflect each patient's condition. No further information was provided prior to the end of the survey process.	F 514		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-IMPERIAL	1719 BELLEVUE AVENUE RICHMOND, VA 23227

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 4/21/15 through 4/23/15. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 128 certified bed facility was 113 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents 1 through 20) and 5 closed record reviews (Residents 21 through 25).	F 000		5/22/17
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: F278 cross reference to 12VAC5-371-240A Resident assessment F 309- cross references to 12 VAC 5 - 371 220 B Nursing Services F387 and F514 are cross referenced to 12VAC5-371-140 Policies and Procedures F387 cross Reference to 12VAC5-371-240 Physician services.	F 001	**Cross Reference** **12VAC5-371-240A Resident Assessment cross reference to F278** **12VAC5-371-220B Nursing Services to cross reference to F309** **12VAC5-371-140 Policies and Procedures cross reference to F387 and F514** **12VAC5-371-240 Physician Services to cross reference to F387** ***Date of compliance is 5/22/17.***	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
N. Threatt, Adm.		5/8/17