ManorCare Health Services of Alexandria 1510 Collingwood Road Alexandria, Virginia 22308 703.765.6107 703.768.6344 fax



October 9, 2018

Wietske G. Weigel-Delano LTC Supervisor Office of Licensure and Certification Division of Long Term Care Services

Dear Ms. Wietske G. Weigel-Delano,

Re: Plan of Corrections

ManorCare Health Services of Alexandria

Provider Number: 495011

Here is this revised plan of corrections for ManorCare Health Services of Alexandria for the standard survey ending August 30, 2018 for your consideration and acceptance. The date of compliance has been revised for all indicated corrections.

Sincerely,

Leslie Jaffey, LNHA

Administrator



COMMONWEALTH of VIRGINIA

M. Norman Oliver, MD, MA State Health Commissioner Department of Health
Office of Licensure and Certification

TYY 7-1-1 OR 1-800-828-1120 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1485 Fax (804) 527-4502

September 14, 2018

Ms. Leslie Jaffey, Administrator Manorcare Health Services-Alexandria 1510 Collingwood Road Alexandria, VA 22308-1605

RE:

Manorcare Health Services-Alexandria

Provider Number 495011

Dear Ms. Jaffey:

An unannounced standard survey, ending August 30, 2018, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Two complaints were investigated during the survey. One complaint was substantiated, with no deficiencies. One complaints was unsubstantiated, with no deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results -

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

DIRECTOR (604) 367-2102 ACUTE CARE 1804) 367-2104 COPH



004PLAINTS

LONG TERM CARE

Ms. Leslie Jaffey, Administrator September 14, 2018 Page 2

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of E), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) <u>must be submitted within ten (10) calendar days of receipt of these survey findings</u> to Wietske G. Weigel-Delano, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.

To be considered acceptable, the PoC must:

- 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the
 deficient practice will not recur;
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
- 5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compilance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.virginia.gov/licensure-and-certification/the-division-of-long-term-care/.

Ms. Leslie Jaffey, Administrator September 14, 2018 Page 3

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
 - Directed Plan of Correction (PoC) (§488,424).
 - State monitoring (§488.422).
 - Directed In-Service Training (§488.425).
- Pursuant to §488.408(d)
 - Denial of payment for new admissions (§488.417).
 - Denial of payment for all individuals (§488.418).
 - Civil Money Penalty, \$50 \$3,000 per day (§488.430, §488.438), effective on the survey ending date,
- Civil money penalties of \$1,000 \$10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Ms. Leslie Jaffey, Administrator September 14, 2018 Page 4

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: "http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Wietske G. Weigel-Delano, LTC Supervisor

Division of Long Term Care

Enclosure

CC:

Joani Latimer, State Ombudsman

Bertha Ventura, Dmas (Sent Electronically)

PRINTED: 09/14/2018 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
20.89 %		495011	B. WING		ا ا	C 08/30/2018	
	PROVIDER OR SUPPLIE	R VICES-ALEXANDRIA	1	STREET ADDRESS, CITY, STATE, ZIP CO 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL I LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	COMPLETION DATE	
E 000	Initial Comments		E 000			1	
F 000 F 584 SS=E	survey was condu- was in substantial 483.73, Requirem Facilities. INITIAL COMMENTAL COMMENTAL COMMENTAL COMMENTAL COMMENTAL COMMENTAL COMPOSITION OF TWO COMPOSITION OF TWO COMMENTAL COMPOSITION OF TWO CO	Medicare/Medicaid standard reted 8/28/18 through 8/30/18. Fere investigated during this are required for compliance 483 Federal Long Term Care e Life Safety Code follow. 8 84 bed certified bed facility of the survey. The survey of 24 current Resident record s #28, 46, 17, 66, 41, 70, 19, 1, 3, 68, 33, 15, 12, 38, 7, 9, 35, 2, osed record reviews (Residents 180 and 225). Ortable/Homelike Environment (1)-(7)	F 000	agreement with the alleged deficiencies herein. To rem compliance with all Federa State regulations, the centraken or will take the action forth in the following plan correction. The following P constitutes the center's alle compliance such that all all deficiencies cited have been be corrected by the date in	mission d nain in al and er has ns set of OC egation of leged en or will		
	comfortable and h	a right to a safe, clean, comelike environment, including receiving treatment and		RECEIV	/ED		
	homelike environr use his or her per possible. (i) This includes e	provide- fe, clean, comfortable, and ment, allowing the resident to sonal belongings to the extent nsuring that the resident can IDER/SUPPLIES AS RESENTATIVE'S SIGN	11 11	OCT 10 VDH/C	- 2/		

Any deficiency statement ending with an asteroid (*) devotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the milents. (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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495011	B. WING			C 08/30/2018	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	(TA 9/71		15	REET ADDRESS, CITY, STATE, ZIP CODE 110 COLLINGWOOD ROAD LEXANDRIA, VA 22308		
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F 584	receive care and sephysical layout of the independence and (ii) The facility shall the protection of the or theft. §483.10(i)(2) Hous services necessary and comfortable in §483.10(i)(3) Clear in good condition; §483.10(i)(4) Privaresident room, as sephysical facilities in all areas; §483.10(i)(5) Adeq levels in all areas; §483.10(i)(6) Comflevels. Facilities in 1990 must maintai 81°F; and §483.10(i)(7) For the sound levels. This REQUIREME by: Based on observation document review, a complaint investigating the facility staff fail environment for 24. The facility staff fail resident's rooms in the facility staff fail resident	ervices safely and that the he facility maximizes resident does not pose a safety risk. I exercise reasonable care for e resident's property from loss ekeeping and maintenance y to maintain a sanitary, orderly, terior; In bed and bath linens that are the closet space in each specified in §483.90 (e)(2)(iv); quate and comfortable tighting fortable and safe temperature tially certified after October 1, in a temperature range of 71 to the maintenance of comfortable NT is not met as evidenced ation, staff interview, facility and in the course of a ation, it was determined that ed to ensure a hornelike of 52 resident rooms. Siled to maintain the walls in 24 in good repair and failed to eabinets had doorknobs and	F5	84	I. Corrective Action The Maintenance Director has created work orders addressing all indicated repairs for residents identified. A strat plan has been initiated to ensure that a indicated repairs are completed within days. Resident # 4, A-side, doorknob replace both doors of television table. Wall bethead of bed repaired. Resident # 5, A-side, wall behind head bed, left of bed and wall adjacent to be door repaired. Door knob replaced on doors of television table. Resident # 8, A-side, wall across from foot of the betto the right of the bed repaired. B-side, small cabinet identified was reand replaced. Resident # 9, A-side, wall behind the the bed repaired. Resident # 11, A-side, door knob replaced on both detelevision table. B-side, wall protector next to bed repaired. Resident # 14, A-side, wall behind hette bed repaired. Resident # 15, A-side, wall behind head of the bed re B-side, section of wall behind head of was painted and door knob replaced colors of television cabinet. Resident # 17, A-side & B-side, wall the head of the bed was repaired.	egic all a 60 eed on hind d of athroom both d, and moved head of ired. ead of paired. the bed on both	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) D/	TE SURVEY OMPLETED C
	PROVIDER OR SUPPLIE	******	11	TREET ADDRESS, CITY, STATE, ZII 510 COLLINGWOOD ROAD ILEXANDRIA, VA 22308		9/30/2018
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F 584	The findings inclu On 08/28/18 at a observations of re following: "Resident room # table with double Each door was m behind head of be gouged. "Resident room # behind the head of wall adjacent to b chipped and gouge revealed a televis the bottom for sto doorknob. "Resident room # across from foot of bed were observe Observation of the small cabinet with bottom. Further of revealed it was st "Resident room # the wall behind the gouged. "Resident room # a television table for storage. Each Observation of the	10.11		Resident # 19, wall behind bed repaired. Resident # 20, A-side, wall of the bed repaired. Resident # 22, A-side and knobs on television cabinet Resident # 24, wall behind bed was repaired. Resident # 27, A-side, wall of the bed repaired. Resident # 29, A-side & B-the head of the bed repaired. Resident # 30, B-side, wall of the bed repaired. Resident # 36, plate cover the wall to the left of the bed Resident # 38, A-side, wall of the bed repaired. After ne surveyor of electrical receptacle box im Resident # 39, B-side, wall of the bed repaired. Resident # 40, A-side, wall of the bed repaired. Resident # 41, B-side, wall of the bed repaired. Resident # 43, B-side, wall of the bed repaired. Resident # 44, B-side, wall of the bed repaired. Resident # 45, A-side & B-the head of the bed repairer. Resident # 46, A-side & B-the head of the bed repairer.	B-side door s repaired. the head of the lead of the behind the head side, wall behind d. behind the head of replaced. behind the head offication from tacle box hanging rector repaired mediately. behind the head side, wall behind d. side, wall behind d.	

PRINTED: 09/14/2018 FORM APPROVED OMB NO. 0938-0391

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F 584	"Resident room # 1 the wall behind the gouged. "Resident room # 1 the wall behind the gouged. Observati revealed a section bed was unpainted missing doorknobs "Resident room # 1 room revealed the	4, A-side of the room revealed head of bed was chipped and 5, A-side of the room revealed head of bed was chipped and on of the B-side of the room of wall behind the head of the and the television cabinet was on each door of the cabinet. 7, A-side and B-side of the wall behind the head of the ed and the B-side bed was	F	584	II. Identification An inspection of resident rooms will completed by administration to detern any other needed repairs. Work order will be created to address needed repair and ensure that all identified needed repairs are completed. III. Systemic Changes Staff education has been completed the ensure that all facility staff are knowledgeable of how to identify a needed repair and how to communic needed repair to maintenance.	nine s airs	
	wall behind head of gouged. "Resident room 20, the wall behind the gouged. "Resident room 22, revealed television room with double d storage. Further of cabinets revealed a on each cabinet. "Resident room 24, wall behind the hear gouged. "Resident room 27,	a private room, revealed the the bed was chipped and A-side of the room revealed head of bed chipped and A and B-side of the room cabinets on each side of the cors on the bottom for eservation of the television a missing a missing doorknob a private room, revealed the dof bed was chipped and A-side of the room revealed head of bed was chipped and		in the second	IV. Monitoring Administration and/or designee will complete weekly room inspections of a month to ensure completed repairs and identify any additional needed repairs. The facility will then complementhly inspections on resident roo to identify needed repairs times two months. The facility's Quality Assurance and Assessment Committee will review weekly/monthly inspection reports the determine trends and ways to address and improve the need for facility repairs. The Administrator and Maintenance Director will work with the corporate Manager of Plant Operations on strategies to improve wall and furniture damage.	ete ms	

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

Event (D: E2S311

Facility ID: VA0177

If continuation sheet Page 4 of 83



STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DAT COM	. 0938-0391 E SURVEY IPLETED	
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F 584	Continued From pa	nge 4	F 584	V. Date of Compliance			
	"Resident room 29, revealed the wall b	, A-side and B-side of the room shind the head of the bed of	1 004	10/04/2018			
	the A-side bed and and gouged.	the B-side bed was chipped					
		B-side of the room revealed head of bed was chipped and		1 a 0 I			
	"Resident room 36, missing plate cover to the left of the be-	a private room revealed a r for the phone jack on the wall d.			-		
	the wall behind the gouged, an electric two-plug outlet with outlet. Further revi	A-side of the room revealed head of bed was chipped and al receptacle box containing a the bed plugged into the ew of the electrical receptacle hanging out of the wall.	æ				
		B-side of the room revealed head of bed was chipped and			10 200		
	"Resident room 40, the wall behind the gouged.	A-side of the room revealed head of bed was chipped and					
		B-side of the room revealed head of bed was chipped and					
		B-side of the room revealed head of bed was chipped and					
	"Resident room 44,	B-side of the room revealed			5201		

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

gouged.

the wall behind the head of bed was chipped and

Event ID: E2S311

Facility ID: VA0177

If continuation sheet Page 5 of 83

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F 584	room revealed the bed of the A-side	45, A-side and B-side of the wall behind the head of the bed and the B-side bed was led. Further observation of the	F	584	_			-(
	room revealed the bed on the A-side gouged.	e wall across from the foot of the of the room was chipped and 46, A-side and B-side of the			n_			
	bed of the A-side chipped and goug							
	of the resident's re (administrative sta and OSM (other s maintenance. Up rooms # 4, # 5 an acknowledged the were missing doo rooms were in po- resident Room # 1 and OSM # 1 observation of 21 the same type of to observe the ne for a list of the resident observed, and sta work orders for so provide those wor 1 further stated the observed each room		*1	78 °C				
	provided this surv	oproximately 4:00 p.m., OSM # 1 reyor with copies of work orders rough 08/29/18. Review of the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011		(X2) MULTIPL A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C		
NAME OF	PROVIDER OR SUPPLIE			TREET ADDRESS, CITY, STATE, ZIP CODE	08/30/2018
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F 584	and /or the missir cabinets for resid	d to evidence repairs to the walls and doorknobs on the television ent room numbers 2, 4, 5, 8, 9. 2, 20, 22, 24, 27, 29, 30, 36, 38,	F 584		
	conducted with A member) # 1, adi had reviewed res 11, 14, 15, 17, 19 39, 40, 41, 43, 45 surveyor's finding stated, "We put a system yesterday July I had a comp and painted room updating the facili come in a couple furniture ordered	A5 a.m., an interview was SM (administrative staff ministrator. ASM # 1 stated she ident room numbers 2, 4, 5, 8, 9. 20, 22, 24, 27, 29, 30, 36, 38, i, and 46 and agreed with this is and observations. ASM # 1 If those rooms on the work order a ASM # 1 further stated, "In pany come in and repaired walls is. We are in the process of ity. I also had a design team of months ago and we had including the wardrobes but the television stands have not been will be next."			A
	interview was cor member) #1, dire asked to describe needed repairs at rooms, OSM # 1 something in nee TELS system (ele they tell their sup system. I check to and the work is p problem like a wa of me immediated asked if he make resident's rooms,	proximately 8:15 a.m., an aducted with OSM (other staff ctor of maintenance. When the process for identifying and making repairs to resident stated, "If an employee finds of repair, they put it in the actronic work order system) or ervisor and they put it in the the TELS several times a day rioritized. If it is an immediate ater leak, they (staff) get a hold y and take care of it." When routine rounds to check the OSM # 1 stated, "Usually every et in about at six in the morning."			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l''	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495011	B. WING			C 08/30/2018	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ii e		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	1 08	002010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(XS) COMPLETION DATE	
F 656 SS≃E	I check lights, wate to the residents' rot they are still asleep week I usually get it get involved in a property of the part of they are still asleep week I usually get it get involved in a property of the part of the par	er anything obvious. I don't go oms because it's too early and p. During the course of the to all the resident's rooms but if project I don't get to it." proximately 12:25 p.m., ASM if member) # 1, the ASM # 2, director of clinical # 3, quality assurance hade aware of the findings. tion was provided prior to exit. It Comprehensive Care Plans facility must develop and brehensive person-centered resident, consistent with the forth at §483.10(c)(2) and at includes measurable reframes to meet a resident's and mental and psychosocial intified in the comprehensive comprehensive care plan must are to be furnished to attain sident's highest practicable and psychosocial well-being as 83.24, §483.25 or §483.40; and at would otherwise be required 83.25 or §483.40 but are not be resident's exercise of rights cluding the right to refuse		The statement made on this plan correction are not an admission of do not constitute an agreement walleged deficiencies herein. To rein compliance with all Federal and State regulations, the center has or will take the actions set forth it following plan of correction. The following POC constitutes the ceallegation of compliance such the alleged deficiencies cited have been or will be corrected the date indicated. It is the practice of the facility to develop and/or implement comprehensive person-centered plans I. Corrective Action 1 resident #41's MD was notified not taken and new order obtained meds now being administered perorder. 1b. resident's #41's nurse was reeducated on offering non-pharmacological intervention prior To administration of as needed medication Resident #2's nurse was re-educ Offering non-pharmacological intervention prior To administration of as needed medication	o and vith the smain d taken n the nter's at all ed by care of BP and mD's		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BULLDING			(X3) DATE SURVEY COMPLETED	
11 1/3000		495011	B. WING			30/2018	
	PROVIDER OR SUPPLIE	R VICES-ALEXANDRIA	1	TREET ADDRESS, CITY, STATE, ZIP CO 510 COLLINGWOOD ROAD ILEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ILSC 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 656	provide as a resurecommendations findings of the PA rationale in the re (iv) In consultation resident's represe (A) The resident's desired outcomes (B) The resident's future discharge, whether the resident community was a local contact age entities, for this period (C) Discharge plan, as appropriate requirements set section. This REQUIREMING. Based on observinterview, facility or record review, it was a staff failed to implicate the resident #41, 2, 2, 2, 3. 1a. The facility staff failed staff failed to implicate the resident #41, 2, 2, 3. 1a. The facility staff failed staff fail	It of PASARR It of PASARR It a facility disagrees with the ISARR, it must indicate its sident's medical record. In with the resident and the entative(s)- Is goals for admission and its. Is preference and potential for Facilities must document ent's desire to return to the essessed and any referrals to include and/or other appropriate urpose. In the comprehensive care ate, in accordance with the forth in paragraph (c) of this ent in the tent as evidenced entered entere	F 656	Upon notification by surveyor r #28's air mattress was immedi on, resident assessed for any and re-education provided to n on checking function of air mai pon notification by the surveyo #35's Head-of-bed was elevate ordered and nursing staff re-ed ensuring that head of bed stay post feeding. esident #11's oxygen is now be administered per MD's order. esident #11's nurse was re-edu offering non-pharmacological is prior to administration of as ne medication. II. Identification All residents residing in the faci the potential to be affected by the alleged deficient practice. III. Systemic Changes Interdisciplinary Team (IDT) will	ately turned discomfort ursing staff tress. r, resident ed as ducated on selevated eling ucated on intervention eded		
1b. The facility staff failed to implement I #41's comprehensive care plan and atternon-pharmacological pain interventions the administration of prn (as needed) pamedications.		sive care plan and attempt ical pain interventions prior to	× 1 1	re-educated to develop and/or implement comprehensive care for all residents.			
		ff failed to implement Resident ive care plan and attempt					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		495011	B. WING	i <u> </u>	Of	C 3/30/2018
	PROVIDER OR SUPPLIER	ICES-ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 656	non-pharmacologic the administration of medications. 3. The facility staff air mattress was or comprehensive pla. 4. The facility staff comprehensive car #35's head of bed to post tube feeding. 5a. The facility staff 11's comprehensive administration of oxide to the facility staff 11's comprehensive administration of oxide to the facility staff 11's comprehensive implementation of oxide to the findings included 1. Resident #41 war 7/13/18 with diagnoral limited to muscle wand atrial fibrillation MDS (minimum data admission assessmenterence date) of coded as being comake daily decision 15 on the BIMS (Bream.	eal pain interventions prior to of prn (as needed) pain failed to ensure Resident #28's and functioning per n of care on 8/29/18. failed to implement the re plan and elevate Resident to 30-45 degrees one hour failed to follow Resident # e care plan for the kygen. If failed to follow Resident # e care plan for the hon-pharmacological	Fe	DON and/or designee will of five (5) random audits of resto ensure that comprehensinglan has been implemented audits will be done weekly and then monthly x two (2). The results of these audits and forwarded to the Quality As and Assessment Committee review and action as appropriate to further audits and/or action. V. Date of Compliance 10/04/2018	sidents ve care l. These c four (4) will be surance e for oriate. ne need	
	(physician order su	t #41's most recent POS immary) signed by the 3, revealed the following order:	:			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILOII	TIPLE CONSTRUCTION NG	3.57	COM	E SURVEY PLETED
NAME OF I	PROVIDER OR SUPPLIE	495011	B. WING	STREET ADDRESS, CITY, STATE	TIP CODE	08/	30/2018
		VICES-ALEXANDRIA		1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	2 ZIF CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	OTHE APPROP	BE	(X5) COMPLETION DATE
F 656	"Lisinopril 25 mg (every day) for HT for SBP (systolic I 120." This order volume of Review of Reside (medication admir Lisinopril was admir 8/29/18. There we pressures on the Review of the vital care) in the electropressures were of following dates: 8/12/18, 8/19/18, There was no evic remaining 22 days. Resident #41's care documented in particular disease related to experience effect the quarter. Interview per physician's or On 8/29/18 at 9:5 conducted with Resident her blood pressure checked supposed to be more of the pressure checked supposed to the mirror on 8/30/18 at 11:1 conducted with Life of the pressure checked supposed to the mirror of the pressure checked supposed to the mirror of 8/30/18 at 11:1 conducted with Life of the pressure checked supposed to the mirror of th	(milligrams) po (by mouth) qd (N (high blood pressure), Hold blood pressure) (2) less than vas initiated on 8/1/18. Int #41's August 2018 MAR inistration record) revealed ininistered 8/1/18 through ere no documented blood MAR. Il sign tab on PCC (point click onic record, revealed blood btained and documented on the /1/18, 8/2/18, 8/3/18, 8/5/18, and 8/26/18. Idence of blood pressures for the is in the clinical record. Indiac care plan dated 7/17/18 art, the following: "Cardiac I Hypertension Goal: Will ave symptom management over rentions: Administer medication der." 7 a.m., an interview was esident #41. When asked how ressure was checked, Resident the barely gets her blood and was not sure if it was hore frequent. 27 a.m., an interview was PN (licensed practical nurse) #2,	F 64	56			
	Resident #41's nu process staff follo	urse. When asked about the ws when a resident has bood pressure medication, LPN	ij	3 -			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A, BUILDING	CONSTRUCTION		TE SURVEY MPLETED C	
d.	PROVIDER OR SUPPLIE	495011 R VICES-ALEXANDRIA	8. WING	CODE	8/30/2018	
(X4) ID PREFIX TAG			ID PREFIX TAG	(X5) COMPLETION DATE		
F 656	#2 stated that nui blood pressure, a range for the med the medication shall be received by the property of the physician alternations with the blood pressure of the pressure of the care plan should the care plan should the received pressure of the care plan should the received pressure of the care plan should the care plan should the care plan should the care pressure of the resident is received by the pressure of the care plan should the care pl	page 11 resing should check the resident's and if the blood pressure is out of dication to be administered, then tould be held. LPN #2 stated, so needs to be made aware if the medication is held." LPN #2 cod pressure should be checked administering blood pressure parameters. When asked is sures were documented, LPN to pressure should be the MAR. When asked if cod pressures were er MAR, LPN #2 confirmed that were missing and not the MAR. LPN #2 stated blood are been documented in the his writer showed LPN #2 confirmed the mis writer showed LPN #2 confirmed the stated that she wouldn't know. When asked how she Resident #41's blood pressures or to the administration of Lisinopril, hower. When asked if the order N #2 stated that the above order When LPN #2 was asked the tre plan, LPN #2 stated that the tre plan was to alert nursing staff the resident. When asked if the befollowed, LPN #2 stated that the tre plan was to alert nursing staff the resident. When asked if the befollowed, LPN #2 stated that the tre plan was to alert nursing staff the resident. When asked if the befollowed, LPN #2 stated that the tre plan was to alert nursing staff the resident. When asked if the plan was to alert nursing staff the resident. When asked if the plan was to alert nursing staff the resident. When asked if the plan was to alert nursing staff the resident. When asked if the plan was to alert nursing staff the resident. When asked if the plan was to alert nursing staff the resident. When asked if the plan was to alert nursing staff the resident. When asked if the plan was to alert nursing staff the resident. When asked if the plan was to alert nursing staff the resident. When asked if the plan was to alert nursing staff the resident was to alert nursing staff the resident was to alert nursing staff the resident was to alert nursing staff	F 656			

AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILOIR B. WING	IPLE CONSTRUCTION	00	TE SURVEY MPLETED C W30/2018
	PROVIDER OR SUPPLIE	NIVICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZI 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		W3W2U16
(X4) ID PREFIX TAG	(EACH DEFICIEN	ITATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656	On 8/30/18 at 12 staff member) #1 DON (Director of Quality Assurance the above concert. The facility policy Planning," docum "Purpose: To prointerdisciplinary of plan is a communimembers of the lin how to meet ealso identifies the the patient should the care plan is dimplement the implan. These may administering tree performing there activities with the (1) Lisinopril is used the heart failure. From The National the heart failure. Too 10968/?repositional too caused by your heart failured as a syst This Information Institutes of Heal	225 p.m., ASM (administrative, the administrator, ASM #2, the Nursing), and ASM #3, the e Consultant was made aware of ms. It titled, "Interdisciplinary Care nents in part, the following: vide guidelines on the process of are planning. The patient's care nication tool that guides nterdisciplinary healthcare team ach individuals patient's needs. It is types and methods of care that directiveImplementation: Once leveloped, the staff must terventions identified in the care include, but is not limited to: atments and medications, pies, and participating in patient." sed to treat high blood pressure This information was obtained all Institutes of Health. Inm.nih.gov/pubmedhealth/PMH t=details. I pressure "is the pressure eart contracting and pushing out bod pressure for adults is olic pressure of less than 120." was obtained from The National	1 m			

STATEMENT OF DEF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE S COMPL		E SURVEY IPLETEO
_		495011	B. WING					C 3 0/2 018
NAME OF PROVIDE		/ICES-ALEXANDRIA	•	15	REET ADDRESS, CITY, STATE, ZIP COL 10 COLLINGWOOD ROAD .EXANDRIA, VA 22308	DE	2	Wh.
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
1b. T #41's non-p the ai media Resid 7/13/ limite and a MDS admirefere code make 15 or exam Revie POS follow 1 tab for pa Revie (med Resid dates 7/18/ 7/19/ 7/20/ 7/23/ 7/24/ 7/27/ For 7 pain	comprehens charmacologi dministration cations. fent #41 was 18 with diagn d to muscle v atrial fibrillatio (minimum da ssion assessi ence date) of d as being co e daily decision the BIMS (B d). ew of Resider (physician or ring order: "T (tablet) by m ain." ew of Resider ication admin fent #41 rece diagram 18 at 9 a.m. 18 at 9 a.m. 18 at 9 a.m. 18 at 9 a.m. 18 at 9:00 a.r 18 at 10:00 p //27/18, there scale/evaluat	If failed to implement Resident ive care plan and attempt cal pain interventions prior to of pm (as needed) pain admitted to the facility on oses that included but were not weakness, high blood pressure, n. Resident #41's most recent at set) assessment was an ment with an ARD (assessment 7/20/18. Resident #41 was gnitively intact in the ability to ans scoring 15 out of possible trief Interview for Mental Status) at #41's July and August 2018 der summary) revealed the ramadol (1) 50 mg (milligrams) outh every 8 hours as needed at #41's July 2018 MAR distration record) revealed that ived Tramadol on the following m.		656				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE S COMPL	
6.1107576		495011	B. WING		_	V2018
	PROVIDER OR SUPPLIE CARE HEALTH SER	R VICES-ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(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 CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	Continued From p	page 14	F 65	56	n 8	= 1
	interventions were	non-pharmacological pain relief e attempted prior to the Tramadol for all above dates.		11		
	failed to evidence interventions were administration of	ont #41's July nursing notes that non-pharmacological pain attempted prior to the Tramadol on the above dates. Irsing notes that addressed ain on 7/27/18.			1 10	3
	(medication admi	nt #41's August 2018 MAR nistration record) revealed that elved Tramadol on the following		1 II		
	8/6/18 8/8/18 8/11/18 8/18/16 8/20/18 8/22/18 8/28/18					
	was no evidence on the back of the evidence that nor interventions were administration of August nursing no	8, 8/18/18 and 8/22/18 there of location of pain documented August MAR. There was no e-pharmacological pain relief attempted prior to the Tramadol for all above dates. Dies could not be found in the parding Resident #41's pain for	1			
	7/13/18 documen "Implement non-p such as music, po	ent #41's pain care plan dated ted the following intervention: charmacological interventions ositioning, or OOB (out of bed) elchair to assist with pain and				

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CEIALEL	13 FOR MEDICARE	a MEDIONID SETTICES			<u></u>	<u> </u>	1 800-0060	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495011	B. WING	1		(20/2019	
		1	0			<u> </u>	30/2018	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
MANOR	CARE HEALTH SERV	ICES_ALEYANDDIA		1	510 COLLINGWOOD ROAD			
MINION	MUE HEVELH SENA	IOLO-ALLAANDRIA		A	LEXANDRIA, VA 22308			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	Ю	_	PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	1	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE	
			ļ		DEFICIENCY			
			ĺ					
F 656	Continued From pa	ige 15	F	656				
	monitor for effective	eness."						
	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						į	
	On 8/29/18 at 9:57	a.m., an interview was						
		sident #41. When asked if staff	İ					
		uch a hot therapy, massage	1					
		a prn pain medication,						
		d that she was just given a pill.	ł					
	On 8/30/18 at 11:23	7 a.m., an interview was						
		V (licensed practical nurse) #2,						
		se. When asked about the						
		s when administering prn (as	Ì					
		cations, LPN #2 stated that	l					
		sking the patient their level of	i		i			
		m 1-10 (10 being the worst						
		then go check the prn (as						
		cations. LPN #2 stated that	<u> </u>		(
		pain level, when it started, and	i		1			
		ications she can give. LPN #2	<u></u>		1			
		in medication is administered,	1					
		and reassess pain after 30	1					
		stated that this information						
		nted on the back of the MAR.						
	*******	was documented on the back						
		2 stated, "Time, date, my						
		z stateu, Time, date, my lication, pain level." When						
,		n of pain was part of the pain						
l I								
		#2 confirmed that it was and						
		should be documented. LPN						
		pain assessment was not on						
		R, that it may be documented						
		When asked if other						
		in relief should be attempted,						
·		ng pain medications, LPN #2						
		uld attempt sometimes. LPN			i e		!	
		could tell by talking to the	Ì					
		rmacological pain relief	l				{	
		work. LPN #2 stated the						
1	L regident may also a	refuse When seked if			I		ı	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING CO		ATE SURVEY OMPLETED C 8/30/2018		
	PROVIDER OR SUPPLIE	R IVICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		30/2018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 656	non-pharmacologileast offered prior LPN #2 stated, "before giving med documented anyonon-pharmacologiattempted or offeinformation should note. When aske attempt non-pharinterventions prior medications, LPN managed by othe above concerns. #41 requested he resident knew whagain if non-pharmattempted before is given, LPN #2 asked the purpos stated that the purpos stated that the purpos tated that the purpos tated that the purpos stated that the purpos stated that the purpos tated th	r to giving prn pain medications, res, it should be done each time dication." When asked if it was where in the clinical record that gical interventions were red, LPN #2 stated that that d be documented in a progress ad why it was important to reach the to administering pain I #2 stated that the pain could be remans. LPN #2 confirmed the LPN #2 stated that Resident or pain medication and that the pain medication and that the pain sked macological should be offered or any as needed pain medication stated yes. When LPN #2 was se of the care plan, LPN #2 prose was to alert nursing staff the resident. When asked if the be followed, LPN #2 stated that suld be followed to ensure the ing appropriate care. LPN #2 esident #41's care plan was not there was no evidence that gical pain interventions were attempted.		56			
	staff member) #1 DON (Director of	, the administrator, ASM #2, the Nursing), and ASM #3, the e Consultant was made aware of					
	severe pain. This	algesic used to treat moderate to s information was obtained from de for Nurses, 11th edition p.					

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	OF DEFICIENCIES OF CORRECTION				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495011	B. WING			ı	C 30/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-ALEXANDRIA		16	REET ADDRESS, CITY, STATE, ZIP CODE 10 COLLINGWOOD ROAD EXANDRIA, VA 22308		100 714
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
F 656	Continued From pa	age 17	F	656			
	#2's comprehensiv non-pharmacologic	failed to implement Resident re care plan and attempt cal pain interventions prior to of pm (as needed) pain					
	5/17/18 with diagnoral limited to type two hypothyroidism, pospinal stenosis. Roundling (minimum data set assessment with a	st stroke, and back pain with esident #2's most recent MDS) assessment was a quarterly n ARD (assessment reference					
	being cognitively in decisions scoring to Interview for Mental was coded as requience staff members unit; extensive assignity with transfers, pers	Resident #2 was coded as atact in the ability to make daily 5 out of 15 on the BIMS (Brief at Status) exam. Resident #2's airing limited assistance from with locomotion on and off the istance with one staff member sonal hygiene, and bathing; and on staff with dressing.					
	POS (physician order: "lb	nt #2's July and August 2018 der summary) documented the uprofen 200 mg (milligrams), o (by mouth) q (every) 8 hours eadache."					
	MAR (medication a	nt #2's July and August 2018 administration record) revealed buprofen on the following dates					is.
		n. and 7/31/18 at 12:00 p.m., and 8/25/18 at 3:30 a.m.					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011		PLE CONSTRUCTION G	COM	E SURVEY IPLETED C 30/2018
	PROVIDER OR SUPPLIE	RVICES-ALEXANDRIA	i	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		11011231 St. 24 1
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(XS) COMPLETION DATE
F 656	Continued From	page 18	F 650	6	. =	1
; !	to evidence pain up pain assessm	ly and August 2018 MARS failed scales for the above dates follow ents and non-pharmacological impted prior to the administration	1			
	note dated 8/25/1 following: "Reside Ibuprofen (sic) ac pain 0/10" This non-pharmacolog	ent #2's nursing notes revealed a 18 that documented in part, the ent c/o (complaints) pain 3/10. dministered 400 mg resulting in a note did not address gical interventions attempted histration of the Ibuprofen.				
		ould be found in the clinical Resident #2's pain on the above		-		
	documented the full "Implement non-rustic, per such as music, per such	in care plan dated 5/17/18 following intervention: oharmacological interventions ositioning or other activities of with pain and monitor for			CONT. IN	
	conducted with LI When asked about administering properties of the	27 a.m., an interview was PN (licensed practical nurse) #2. ut the process staff follows when a (as needed) pain medications, at nurses should be asking the of pain on a scale from 1-10 (10 ossible pain), and then go checked) pain medications. LPN #2 ould ask the pain level, when it what pain medications she can ted that once pain medication is a would go back and reassess utes. LPN #2 stated that this				

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C C B. WING D8/30/2	
00/30/2	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	2018
MANORCARE HEALTH SERVICES-ALEXANDRIA 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) OMPLETION DATE
F 656 Continued From page 19 information should be documented on the back of the MAR. When asked what was documented on the back of the MAR. LPN #2 stated, "Time, date, my initials, type of medication, pain level." When asked if location of pain was part of the pain assessment, LPN #2 confirmed that it was and that location of pain should also be documented. LPN #2 stated that if the pain assessment was not on the back of the MAR, that it may be documented in a nursing note. When asked if other interventions for pain relief should be attempted first, prior to administering pain medications, LPN #2 stated that she would attempt sometimes. LPN #2 stated that you could tell by talking to the resident if non-pharmacological pain relief interventions would work. LPN #2 stated that the resident may also refuse. When asked if non-pharmacological interventions should be at least offered prior to giving as needed pain medications, LPN #2 stated; "Yes, it should be done each time before giving medication." When asked if it was documented anywhere in the clinical record that non-pharmacological interventions were attempted or offered, LPN #2 stated that that information should be documented in a progress note. When asked why it was important to attempt non-pharmacological pain relief interventions prior to administering pain medications, LPN #2 stated that the pain could be managed by other means. LPN #2 confirmed the above concerns. When LPN #2 was asked the purpose of the care plan, LPN #2 stated the care plan was to alert nursing staff on the needs of the resident. When asked if the care plan should be followed, LPN #2 stated that the care plan should be followed to ensure the resident is receiving appropriate care. LPN #2 confirmed that the pare	

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VDH/OLC

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011		IPLE CONSTRUCTION NG	- 57	COM	E SURVEY IPLETED
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, 2 1610 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	IP CODE	30/2018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL ILSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD	BE	(X5) COMPLETION DATE
F 656	evidence that non interventions were On 8/30/18 at 12: staff member) #1, DON (Director of Quality Assurance the above concern (1) Ibuprofen is a drug used to treat information was of Institutes of Healt	n-pharmacological pain be being offered or attempted. 25 p.m., ASM (administrative, the administrator, ASM #2, the Nursing), and ASM #3, the e Consultant was made aware of ns. non-steroidal anti-inflammatory mild to moderate pain. This obtained from The National h.	F 65	56			
	air mattress was of comprehensive placement #28 was 2/9/18 with diagnoral limited to severe paided weakness paidsease and chronic unspecified deep Resident #28's mosel) assessment with assessment with a date) of 6/27/18. being severely improving 02 out of placement was coded in section on stage was present upon	f failed to ensure Resident #28's on and functioning per lan of care on 8/29/18. sadmitted to the facility on oses that include but were not protein deficiency, left and right cost stroke, coronary arterial nic embolism and thrombosis of velns of the lower extremities. Ost recent MDS (minimum data was a significant change an ARD (assessment reference Resident #28 was coded as paired in cognitive function possible 15 on the BIMS (Brief all Status) exam. Resident #28 tion M (Skin Conditions) as three (1) pressure ulcer* that admission, two stage four (2) at were present upon					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION			DATE SURVEY COMPLETED	
		495011	B. WING					3 <u>0/2018</u>	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-ALEXANDRIA		18	TREET ADDRESS, CITY, STATE, ZIP (B10 COLLINGWOOD ROAD LEXANDRIA, VA 22308	OODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 656	admission and two sores that were pre Resident #28 was a Treatments, Proced hospice services. I as having severe w (Swallowing/Nutritic was coded as required from one staff merridaily living). Review of Resident dated 8/22/18 docution to the staff merridaily living and the staff merridaily living. Review of Resident dated 8/22/18 docution to the staff merridaily living and the staff merridaily living. Review (Centimeters) (width) X 0.2 cm (District Left lateral ankle X 2.5 cm X 0.2 cm. Left buttock (Stage 10.2 cm. Left heel (Stage 10.2 cm. Right lateral foot X 2 cm X 0.2 cm. Right lateral foot X 2 cm X 0.2 cm. Left medial foot (0.2 cm." Review of Resident Order Summary) respectific treatment is documenting that the completed on the Administration recompleted of Resident plan dated 2/9/18 at 12.	unstageable (3) pressure unstageable (3) pressure usent upon admission. Coded in Section O (Special dures, Programs) as receiving Resident #28 was also coded reight loss in Section K conal Status). Resident #28 iring extensive assistance other with all ADLs (activities of the #28's weekly skin/wound note remented the following wounds: e (stasis ulcer) (4) measuring (L) (length) X 2.5 cm (W) (depth). (stasis ulcer) measuring 3 cm (geable) measuring 3 cm X 3 cm X (unstageable) measuring 3 cm X 4 (unstageable) measuring 2 cm stasis ulcer) 2 cm X 7.8 cm X (the #28's August 2018 (Physician evealed that each wound had a in place. Staff were reatments were being august 2018 TAR (treatment and).	F	656					

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 495011		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CO 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		30/2018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	skin integrity relations normal progressing processInterver device to bed" Further review of documented the foliation of the state of Resident She had an air mand functioning. On 8/28/18 at 4:3 made of Resident She had an air mand functioning. On 8/28/18 at 7:4 made of Resident She had an air mand functioning. On 8/29/18 at 7:4 made of Resident Her air mattress with the state of Resident Her air mattress	ted to: immobility, incontinence, we decline in disease nations: Pressure redistributing Resident #28's care plan following: "Pressure Ulcer to Lived to: impaired mobility due to	F 656				
	stated that she at and that her appe some time. CNA in the resident's nathis writer made a room. Her air ma On 8/29/18 at 9:0	tempted to feed Resident #28 title has been poor for quite #2 confirmed that she was just porm. On 8/29/18 at 8:54 a.m., in observation of Resident #28's ttress was unplugged and off. 7 a.m. and 9:27 a.m., and 9:28 and off.					

- OCITIES	10 / OTT MEDIOMILE	W MEDIONID CENTROLO				T		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL		E CONSTRUCTION		E SURVEY PLETED	
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- 21		495011	B. WING			08/	30/2018	
NAME OF I	PROVIDER OR SUPPLIER			· "	TREET ADDRESS, CITY, STATE, ZIP CODE			
MANORO	CARE HEALTH SERV	ICES-ALEXANDRIA			510 COLLINGWOOD ROAD		-	
				<u> </u>	LEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 656	Continued to be unated to be unated to be unated to Reside followed CNA #2 in explained that she out of bed for an act #2 noticed about R #2 looked at the moff. CNA #2 tried to wouldn't turn on. C Resident #28's bed mattress) was unple Resident #28's air how long the mattre stated that she thow when she washed asked what time she CNA #2 stated, "Juinformed of the about the stated that she thow the she washed asked what time she con the about the she washed asked what time she con the about the she washed washed the about the she washed asked what time she con the she washed the about the she washed the s	•	F	656				
	conducted with LPI Resident #28's nur responsible for ens and functioning, LFI responsibility, inclu mattress is on and asked if she had be that morning, LPN her room during the if Resident #28 she mattress on her be #2 stated Resident functioning early the Resident #28 need	3 a.m., an interview was N (licensed practical nurse) #2, se. When asked who was suring air mattresses were on PN #2 stated it was the nurse's ding CNAs to ensure an air functioning properly. When seen in Resident #28's room #2 stated that she had been in a early morning. When asked buld have a functioning air ad, LPN #2 stated, "Yes." LPN #2 stated, "Yes." LPN #28's air mattress was on and that morning. When asked why led an air mattress, LPN #2 that #28 had ulcers to her feet						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
1.00		495011	B. WING		C 08/30/2018
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA				1 0030/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPRIDEFICIENCY)	ULD BE COMPLETION
F 656	above observation must have accider mattress when the #2 stated that hos on Wednesdays. Checking her mattre	age 24 In LPN #2 was informed of the s, LPN #2 stated that hospice ntally unplugged her air by came in that morning. LPN pice usually comes in by 7 a.m. When asked if staff should be ress every time they enter her firmed that staff should.	F 6	56	
	was asked to see I ASM #2 stated that already completed	roximately 10:30 a.m., ASM #2 Resident #28's wound care. It the physician and nurse had it early that morning. This see Resident #28's wound	1	= 1 100	38.1 0
	8/29/18, document	at #28's skin/wound note dated ted the following pressure and with new orders for each		= = = = = = = = = = = = = = = = =	
	integrity measuring (length) X 13.0 cm (depth). Tissue typ with moderate sero present upon admistrength Dakins (5	age IV (four): Altered skin g at 10 cm (centimeters) (L) (W) (width) X 0.2 cm (D) be is 100 percent granulating bus drainageThis wound was ission. Treatment: 0.25 percent color soaked with gauze dsg (dressing) daily.			
	stasis ulcer /PVD (etiology per wound merged): Altered s (L) X 22.0 (W) x 0. emerged from mul on admission. Tres	(three) and left medial foot peripheral vascular disease) IMD (medical doctor) (Now kin integrity measuring at 9.0 6 cm (D)This wound tiple wounds on same location alment: lodosorb (6) to open n (7) to scabbed area. Cover			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				Q	(X3) DATE SURVEY COMPLETED		
36015		495011	B. WING	B. WING				C 08/30/2018	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 656	Right heel and rigiulcers (Now merg per wound MD. A at 9.0 (L) X 22.0 (Voldosorb to open area. Cover with a conducted with LF asked the purpose stated the care plated the needs of the replan should be folloare plan should be folloare plan should tresident is receiving asked if Resident mattress Resident air mattress was a stated that the care on 8/30/18 at 9:00 was conducted with wound care nurse concerns related to care. On 8/30/18 at 12:12 staff member) #1, DON (Director of Quality Assurance the above concerns related to a power of the skin over a bound of the s	ht lateral foot unstageable ed) stasis ulcer/PVD etiology litered skin integrity measuring W) X 0.6 cm (D)Treatment: area and Bactroban to scabbed lry dressing." 27 a.m., further interview was PN #2. When LPN #2 was e of the care plan, LPN #2 an was to alert nursing staff on esident. When asked if the care lowed, LPN #2 stated that the period for an air that was been was followed, if the off and unplugged, LPN #2 e plan was not being followed. 28 a.m., wound care observation the RN (registered nurse) #4, the and LPN #1. There were no on the above wounds or wound working), and ASM #3, the Consultant was made aware of		656					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA				08/30/2018		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL ILSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 656	ulcers may be preposition, early am skin lubricants an called bedsores. I Dictionary of Med Reader 2006; Mik Charles F. Chapm (1) Stage III: Full Subcutaneous fat tendon or muscle be present but do tissue loss. May in tunneling. Further The depth of a stanatomical locatic occiput and malle tissue and stage I contrast, areas of develop extremely Bone/tendon is not This information of Pressure Ulcer Achttp://www.npuap. (2) Stage IV: Full exposed bone, teleschar may be present be pressure Ulcer Achttp://www.npuap. (2) Stage IV: Full exposed bone, teleschar may be pressure Ulcer Achttp://www.npuap. (2) Stage IV: Full exposed bone, teleschar may be pressure Ulcer Achttp://www.npuap. (2) Stage IV: Full exposed bone, teleschar may be pressure Ulcer Achttp://www.npuap. (2) Stage IV: Full exposed bone, teleschar may be pressure Ulcer Achttp://www.npuap. (2) Stage IV: Full exposed bone, teleschar may be pressure Ulcer Achttp://www.npuap. (2) Stage IV: Full exposed bone, teleschar may be pressure Ulcer Achttp://www.npuap.	mobilized persons, decubitus evented by frequently change of bulation, cleanliness, and use of da water or air mattress. Also Pressure sores. Barron's ical Terms for the Non Medical sel A. Rothenberg, M.D. and man. Page 155. Thickness tissue loss. The visible but bone, are not exposed. Slough may es not obscure the depth of include undermining and description: The bridge of the nose, ear, olus do not have subcutaneous il ulcers can be shallow. In significant adiposity can by deep stage ill pressure ulcers. It visible or directly palpable. It visible or directly palpable.	F 65	6	- 0	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495011	B. WING		08	C 3/30/2018		
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 COLLINGWOOD ROAD ALEXANDRIA, VA 22308					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X6) COMPLETION DATE		
F 656	obtained from: The Advisory Panel well http://www.npuap.org/ (3) Unstageable:Further which the base of the Cyellow, tan, gray, gottan, brown or black description: Until erremoved to expose true depth, and the determined. Stable erythema or fluctual serves as "the body and should not be a obtained from The Advisory Panel well http://www.npuap.org/ (4) Stasis Ulcer (Vedefined as open less ankle joint that occidisease. This informational Institutes of https://www.ncbi.nl. 44244/. (5) Dakins Solution and treat infections information was oblinstitutes of Health https://dailymed.nlr.	National Pressure Ulcer posite at pressure ulcer is covered by slough the ulcer is covered by slough treen or brown) and/or eschark) in the wound bed. Further rough slough and/or eschar is the base of the wound, the refore stage, cannot be (dry, adherent, intact without ince) eschar on the heels y's natural (biological) cover removed. This information was National Pressure Ulcer posite at pressure Ulcer posite at pressure ulcer posite at pressure of venous mation was obtained from The of Health. The antimicrobial used to prevent to fithe skin and wound. This tained from The National	F 6	556				
	is a suitable dressi such as venous uld	owder containing iodine, which ng for granulating wounds ers. as obtained from The National						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION	ÇON	E SURVEY IPLETED	
NAME OF PROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIF		30/2018		
MANORCARE HEALTH SERVICES-ALEXANDRIA				1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	WE BY HEAL		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BE BE APPROPRIATE	(X5) COMPLETION DATE	
F 656	(7) Bactroban- and for the treatment of disorders, nasal in This information with the last treatment of the la	in. Im.nih.gov/pubmed/3926169. antibiotic that is used primarity f primary and secondary skin fections, and wound healing. as obtained from The National in. cbi.nlm.nih.gov/compound/Mupi	F 6	356			
	comprehensive ca #35's head of bed post tube feeding. Resident #35 was 4/2/2009 and read diagnoses that incl	failed to implement the re plan and elevate Resident to 30-45 degrees one hour admitted to the facility on mitted on 7/29/2014 with uded but were not limited to		10			
	cerebrovascular di (difficulty swallowin status, and vascular most recent MDS (assessment was a ARD (assessment Resident #35 was cognitive function son the BIMS (brief exam). Resident # total dependence of locomotion, toiletin hygiene; and extentransfers. Resident	sease (stroke), dysphagia ag with NPO (nothing by mouth) ar dementia. Resident #35's (minimum data set) quarterly assessment with an reference date) of 7/11/18. coded as severely impaired in scoring 02 out of possible 15 interview for mental status 135 was coded as requiring on two of more staff with eating, g, bathing, and personal sive assistance from staff with the 435 was coded in Section K onal Status) as having a					
	Review of Residen	t #35's August 2018 POS					

CENTE	10 TOT MICDIOMIL	A INCUIDAD BERVICES				1410 140.	0000-0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		495011	B. WING				3 0/2018
	PROVIDER OR SUPPLIER	ICES-ALEXANDRIA		1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD NEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	(physician order su following order: "Je hour. Start at 4 p.m infused via gast (gast except) Review of Resident plan dated 7/20/18 "Need for feeding twith NPO (nothing statusInterventior 30-45 degrees durion on 8/29/18 at 7:45 made of Resident frunning at 84 ml/hr elevated at least 30 on 8/29/18 from 8: medication pass with 35's nurse, who we have on the unit. On 8/29/18 at 8:22 Resident #35's docurring assistant]) providing care to Romal of Resident #35's docurring assistant] providing care to Romal of Resident #35's docurring assistant] on 8/29/18 at 8:37 made of Resident #35's docurring assistant #35's	mmary) documented the vity 1.2 at 84 ml (milliliters) an and run until 1176 mls have astronomy tube) (1)." It #35's comprehensive care documented the following: ube r/t (related to) dysphagia by mouth) as: elevate the head of bed ang and 1 hour post feeding." a.m., an observation was #35. Her tube feed on was on a. Her head of bed was 0 degrees. OO a.m. until 8:10 a.m., as observed with Resident was also the only medication a.m., this writer knocked on a.m., this writer knocked on a.m., this writer knocked on a.m., the aide (CNA [certified #2 stated that she was resident #35. a.m., an observation was #35. Her tube feed equipment acted and removed from her ast observed up and running. a.m., Resident #35's head of a completely flat. a.m., Resident #35 was		656			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	28864	COM	E SURVEY PLETED C 30/2018
MANORCARE HEALTH SERVICES-ALEXANDRIA		1	211 0	CILED I			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVI) BE	(X5) COMPLETION DATE
F 656	conducted with LP Resident #35's nurshe took down Res 8/29/18. LPN #2 st but that it was whe morning medicatio provided ADL (acti #2 was asked how elevated for reside feeding and immed stated the head of degrees. When as residents with tube bed elevated post resident could aspi of bed should neve feeding. When ask Resident #35's hea yesterday within th window, LPN #2 st this. LPN #2 confii plan instructed the of bed elevated to feeding. LPN #2 st access to the care #2 of the above ob that the care plan w observed that Resi completely flat. CNA #2 could not to On 8/30/18 at 12:2 staff member) #1, DON (Director of N	age 30 77 a.m., an interview was N (licensed practical nurse) #2, rse. LPN #2 was asked when sident #35's tube feed on lated she could not remember in she gave Resident #35 her ins and before the aide vities of daily living) care. LPN the head of bed should be ints with a tube feed during the diately post feeding. LPN #2 bed should be elevated 35-40 sked why it was important for a feedings to have the head of feeding, LPN #2 stated that the irate. LPN #2 stated the head or be flat immediately post tube and of bed was completely flat in the irate. LPN #2 stated the head or be flat immediately post tube and of bed was completely flat in the irate one hour post feeding atted that she was not aware of remed that Resident #35's care nursing staff to keep the head 30-45 degrees one hour post atted that all nursing staff had plan. This writer informed LPN servations. LPN #2 confirmed was not followed if it was ident #35's head of bed was be reached for an interview. 5 p.m., ASM (administrative the administrator, ASM #2, the lursing), and ASM #3, the Consultant was made aware of					3,

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
20		495011	B. WING		,	1	30/2018
	OVIDER OR SUPPLIER	CES-ALEXANDRIA		15	REET ADDRESS, CITY, STATE, ZIP CODE 110 COLLINGWOOD ROAD LEXANDRIA, VA 22308	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(XS) COMPLETION DATE
	On 8/30/18 at 12:52 conducted with CNa conducted with CNa corocess followed by care to a resident what she would call eeding so that it is hat she would lower, but not all the could aspirate. CN/after care she would up and then call the could aspirate. CN/after care she would up and then call the could aspirate. CN/after care she would up and then call the could aspirate out that he head of bed showninimum of 30 min completed. When a confollow the facility ASM #2 stated that #35's care plan docare plan should be care plan should be completed for the primary indicated the primary indicated in patients with a further information in the primary indicated in the prim	rom the nursing unit. 2 p.m., an interview was A #1. When asked about the y staff when providing ADL with a tube feed, CNA #1 stated the nurse to unplug the out of the way. CNA #1 stated or the head of bed to provide way down as the resident A #1 stated that immediately d raise the head of bed back o nurse to restart the feeding. Desimately 1 p.m., ASM #2 ly's enteral feed policy. ASM the policy documented that build be elevated for a utes after feedings are usked if she expected her staff policy or resident care plan, she did not realize Resident tumented an hour and that the	F (556			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011		E CONSTRUCTION	COM	TE SURVEY MPLETED C
	PROVIDER OR SUPPLIE	RVICES-ALEXANDRIA	15	TREET ADDRESS, CITY, STATE, ZIP 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308		/30/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	COMPLETION DATE
F 656	Continued From	page 32	F 656			
	5a. The facility st 11's comprehens administration of	aff failed to follow Resident # ive care plan for the oxygen.	l s			П
	02/28/18 and a re diagnoses that in respiratory failure	as admitted to the facility on eadmission of 07/07/18 with cluded but were not limited to e, (1), anemia, (2), depressive diabetes mellitus (4).				1
	set), a quarterly a (assessment refe Resident # 11 as interview for men - 15, 15 - being co decisions. Under	nost recent MDS (minimum data assessment with an ARD prence date) of 06/07/18, coded scoring a 15 on the brief tal status (BIMS) of a score of 0 ognitively intact for making daily a section "O. Special Treatment, Programs" Resident # 69 was ygen therapy."				
	Resident # 11 rev in her wheelchair oxygen by nasal o concentrator. Ob meter on the oxyg	21 p.m., an observation of realed she was dressed, sitting watching television, receiving cannula connected to an oxygen reservation of the oxygen flow gen concentrator revealed the between two and a half and inute.	11			
	Resident # 11 rev wheelchair watch by nasal cannula concentrator. Ob meter on the oxyg	30 p.m., an observation of realed she was sitting in her ing television, receiving oxygen connected to an oxygen eservation of the oxygen flow gen concentrator revealed between two and a half and inute.				

PRINTED: 09/14/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
		495011	B. WING			C 30/2018	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST 8E PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD 8E	(X5) COMPLETION DATE	
F 656	Resident # 11 reversible to the concentrator. Observed oxygen flow rate at The POS (physicia 11 dated "August 2 Oxygen at 2l/M (two nasal cannula contents of the comprehensive dated 07/08/2018 or respiratory (chronic obstructive "Interventions" it do	D p.m., an observation of aled her sitting in her g television, receiving oxygen connected to an oxygen flow en concentrator revealed two liters per minute. In's order sheet) for Resident # 018"documented, "07/07/18 to liters per minute) via (by) inuously." The care plan for Resident # 11 documented, "Focus. Has/At impairment related to COPD to pulmonary disease." Under ocumented, "Administer edical doctor) orders. Date	F	556			
	conducted with LPI 2. When asked to care plan for a resi take care of the pa important to follow patient's health to r care." When aske 11's room the previstated, "Yes I adjus was suppose to be and a half." LPN # comprehensive car oxygen. When ast followed when the	50 a.m., an interview was N (licensed practical nurse) # describe the purpose of the dent LPN # stated, "How to tient." When asked why is it the care plan. "Because of the make sure they get the right d if she entered Resident # lous day, on 08/28/18, LPN # 2 sted the oxygen because it at two liters and it was at two 2 was asked to review the re plan for Resident # 11's ked if the care plan was being oxygen flow rate was not set nysician's orders LPN # 2					

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Event ID: E2S311

Facility ID: VA0177

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011	A. BUILDIN B. WING	PLE CONSTRUCTION G	COM	E SURVEY IPLETED C	
	PROVIDER OR SUPPLIE	NICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP O 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		08/30/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE	
F 656	(administrative sta administrator and services and ASM consultant, were n No further informa References: (1) When not enot lungs into your blo obtained from the https://www.nlm.ni ilure.html. (2) Low iron. This the website:	pproximately 12:25 p.m., ASM aff member) # 1, the ASM # 2, director of clinical I # 3, quality assurance nade aware of the findings. Ation was provided prior to exit. Bugh oxygen passes from your and. This information was		6			
	blue, unhappy, mis Most of us feel this short periods. Clin disorder in which it or frustration interior or more. This info website: https://medlineplus (4) A chronic diseat regulate the amout information was of	ay be described as feeling sad, serable, or down in the dumps. It is way at one time or another for nical depression is a mood feelings of sadness, loss, anger, fere with everyday life for weeks formation was obtained from the s.gov/ency/article/003213.htm. This is in which the body cannot ant of sugar in the blood. This btained from the website: ih.gov/medlineplus/ency/article/					
		ff falled to follow Resident # ve care plan for the	1 100			П	

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

Event ID: E25311

Facility ID: VA0177

If continuation sheet Page 35 of 83



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUI		E CONSTRUCTION		E SURVEY PLETED
sac ar		495011	B. WING				C 30/2018
	PROVIDER OR SUPPLIE	R VICES-ALEXANDRIA		16	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X6) COMPLETION DATE
F 656	intervention. The POS (physici 11 dated "August 325MG (milligram by mouth every definition of the Post of the August 1325MG (milligram) aceta 14 check daily total MG (milligram) tare mouth every 6 (si 07/07/2018" The MAR (medical Resident # 11, dathe above orders evidence the admireview of the August 136/01/18, 08/06/1 Further review of documentation of interventions priori	page 35 If non-pharmacological Itan's order sheet) for Resident # 2018" documented, "MAPAP (1) In [Tylenoi]. 2 (two) tabs (tablets) ay as needed for Paln - max Iminophen 3-4 GM (grams) daily In 07/07/2018." "Tramadol (2) 50 blet. 1 (one) tab (tablet) by In the hours as needed for pain. In the August 2018" documented In the August 2018" documented In the August 2018 MAR failed to Inistration of MAPAP. Further In the MAR revealed Tramadol 50 In the MAR failed to evidence In the MAR failed to evidence In the administration of In (as needed) pain medication.		956			
	dated 08/01/18 the evidence docume interventions prior Resident # 11's a 08/01/18, 08/06/1 The comprehensidated 07/08/2018 for pain related to Under "Intervention non-pharmacolog music, watching"	ess Notes" for Resident # 11 rough 08/29/18 failed to entation of non-pharmacological r to the administration of s needed (prn) Tramadol on 8, 08/12/18 and 08/14/18. rive care plan for Resident # 11 documented, "Focus. At risk immobility, gout, neuropathy." ons" it documented, "Implement pical interventions such as TV or positioning to assist with for effectiveness. Date initiated:			50		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	CON	C /30/2018	
	PROVIDER OR SUPPLIE	RVICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, 2 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	ZIP CODE	100002010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	O7/09/2018." On 08/29/18 at 1: conducted with L! 2. When asked to care plan for a retake care of the pimportant to follow patient's health to care." LPN # 2 was comprehensive opain. LPN # 2 was MAR and progress dated 08/01/18 there was documnon-pharmacolog attempted when fitramadol on 08/0: 08/14/18, LPN # 2 there was no docum-pharmacolog attempted could ystated no. When a followed when the interventions were 2 stated, "No." On 08/30/18 at ap (administrator and services and ASM	1:50 a.m., an interview was PN (licensed practical nurse) # to describe the purpose of the sident LPN # stated, "How to patient." When asked why is it with the care plan. "Because of the practical make sure they get the right was asked to review the are plan for Resident # 11's as asked to review the August as notes dated for Resident # 11 brough 08/29/18. When asked if the plant interventions were Resident # 11 was administered 1/18, 08/06/18, 08/12/18 and 2 stated no. When asked if	F 656				
	References: (1) Acetaminophe moderate pain fro	ation was provided prior to exit. en is used to relieve mild to om headaches, muscle aches, s, colds and sore throats,					

95.11.61	10 I OLI MEDIOMIE	W MEDIONIO CELTTICEO				710 110.	0000-0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED
		495011	B. WING				C 30/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-ALEXANDRIA		15	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656 F 658 SS=D	toothaches, backad vaccinations (shots Acetaminophen mapain of osteoarthriti breakdown of the li in Acetaminophen is it analgesics (pain rereducers). It works senses pain and by information was obhttps://medlineplus.tml. (2) Tramadol is use moderately severe extended-release to used by people whomedication to relieve Tramadol is in a classical copiate (narcotic) and the way the brain a pain. This informati website: https://medlineplus.ml. Services Provided (CFR(s): 483.21(b)(3) Communication outlined by the comustical control of the services provides outlined by the comustical control of the services provides outlined by the comustical control of the services provides outlined by the comustical control of the services provides outlined by the comustical control of the services provides outlined by the comustical control of the services provides outlined by the comustical control of the services provides outlined by the comustical control of the services provided in the services provides outlined by the comustical control of the services provided in the services provides outlined by the comustical control of the services provides outlined by the comustical control of the services provided in the services provides outlined by the comustical control of the services provided in	ches, and reactions to), and to reduce fever. Ly also be used to relieve the s (arthritis caused by the ming of the joints). In a class of medications called lievers) and antipyretics (fever by changing the way the body cooling the body. This tained from the website: Ligov/druginfo/meds/a681004.h and to relieve moderate to pain. Tramadol ablets and capsules are only of are expected to need the pain around-the-clock. The pain around-the-clock algesics. It works by changing and nervous system respond to the cooling the body. Meet Professional Standards	F	656 658	F 658 The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies have been or will be corrected by the date indicated. It is the practice of the facility to follow professional standards. I. Corrective Action Resident #11's orders for pain medication has been clarified.		
		review, it was determined that ed to follow professional					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	COI	TE SURVEY MPLETED
	94.	495011	B. WING	10000		C /30/2018
	PROVIDER OR SUPPLIE	R IVICES-ALEXANDRIA	15	REET ADDRESS, CITY, STATE, ZIP CODE 10 COLLINGWOOD ROAD LEXANDRIA, VA 22308		# <u>###</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS: CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 658	standards of practine survey sample. The facility staff for two as needed which, as needed administered to F. The findings included the findings included the findings included the findings included from the findings included facility and a rediagnoses that increspiratory failure disorder (5), and finding from the finding for mention of the finding for mention of the finding for mention of the finding for activity for mouth every distributed for milligram) acetal check daily total MG (milligram) tall for the first first for the first form of the first form o	etice for one of 30 residents in e, Resident # 11. alled to clarify physician's orders of pain medications to determine I pain medication should be lesident #11.	F 658	II. Identification All residents residing in the facility the potential to be affected by the alleged deficient practice. III. Systemic Changes Licensed nurses will be educated medication transcription, clarifying medications, and MAR documents. IV. Monitoring DON and/or designee will comple five (5) random audits of residents EMAR to ensure that orders are transcribed correctly, instructions clarified, and documentation of rewhen not available. These audits done weekly x four (4) and then mx two (2). These audits will be for to the Quality Assurance and Assessment Committee for review action as appropriate. The commi will determine need for further aud and/or actions. V. Date of Compliance 10/04/2018	on Jation. te sident will be nonthly warded v and ttee	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	CONSTRUCTION		TE SURVEY MPLETED C
	AME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA		15	REET ADDRESS, CITY, STATE, ZIF 10 COLLINGWOOD ROAD EXANDRIA, VA 22308		/30/2018
(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 C (EACH CORRECTIVE ACTK CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 658	The MAR (medica Resident # 11, da the above physici MAR failed to evid MAPAP (Tylenol). MAR revealed Transinistered to Ro8/06/18, 08/12/1 Review of "Progradated 08/01/18 the evidence docume location prior to the Transadol on 08/008/14/18. The comprehensidated 07/08/2018 for pain related to Under "Interventio pain medication poate initiated: 07/07/07/07/07/07/07/07/07/07/07/07/07/0	ation administration record) for ted "August 2018" documented an's orders. The August 2018 dence the administration of Further review of the August amadol 50 MG was tesident #11, on 08/01/18, 8 and 08/14/18. Pess Notes" for Resident # 11 rough 08/29/18 failed to entation of Resident # 11's pain the administration of pm 11/18, 08/06/18, 08/12/18 and occurrented, "Focus. At risk immobility, gout, neuropathy." ons" it documented, "Administer ter MD (medical doctor) orders.	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A. BUILDING

B. WING

C 08/30/2018

MANORCARE HEALTH SERVICES-ALEXANDRIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(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 658	Continued From page 40 telephone interview was conducted with ASM (administrative staff member) # 7, nurse practitioner regarding the administration of Resident # 11's as needed pain medication. When asked about clarification of which, as needed pain medication of MAPAP (Tylenol) and Tramadol should be administered, ASM # 7 stated, "If the pain is really bad they (nurse) should give the Tramadol. The decision is up to the nurse based on the pain level from the patient." When asked if the pain medication should have parameters ASM # 7 stated, "They don't need parameters. I would assume the nurse would know what pain medication to give." On 08/30/18 at approximately 2:05 p.m., a telephone interview was conducted with ASM (administrative staff member) # 8, the facility's medical director regarding the administration of Resident # 11's as needed pain medication. When asked about clarification of which, as needed pain medication of MAPAP (Tylenol) and Tramadol should be administered, ASM # 8 stated, "A pain level number is subjective. It is the discretion of the nurse." On 08/30/18 at approximately 2:30 p.m., an interview was conducted with ASM # 2, director of nursing regarding the administration of Resident # 11's as needed pain medication. ASM # 2 was asked to review the August 2018 MAR and physician's order for MAPAP (Tylenol) and Tramadol for Resident # 11. When asked how a nurse determines which pain medication to administer, ASM # 2 stated, "It depends on the nursing assessment." When asked to describe what the nursing assessment includes for as	F 658	DEPROPRIENCE			
	needed pain medication, ASM # 2 stated, "Get the pain scale zero to ten, ten being worse pain	_				

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Event ID: E25311

Facility ID: VA0177

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	DATE SURVEY COMPLETED
495011 B. WING	06/30/2018
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA STREET ADDRESS, CITY, STATE, 2IP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 658 Continued From page 41 and the location." When asked to describe at what pain level Resident # 11 should receive MAPAP (Tylenol) and at what pain level Resident # 11 should receive Tramadol, ASM # 2 stated, "I'm not a physician." On 08/30/18 at approximately 2:45 p.m., ASM # 8, the facility's medical director called the facility and spoke with this surveyor stating he wanted to clarify the earlier conversation regarding the administration of prn pain medication. ASM # 8 stated that the nurse's decision is based on the clinical symptoms of the patient at the time." On 08/30/18 at approximately 3:00 p.m. and interview was conducted with ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services and ASM # 3, quality assurance consultant. A request was made for any standard or information such as the nursing practice act and or code of Virginia, evidencing that it is within a nurse's scope of practice, to make the determination of which as needed prin pain medication to administer to residents with orders for more than one as needed pain medications without pain parameters. A request was also made to provide documentation of what a complete physician's order entails. At 4:00 p.m., ASM # 3 stated they were unable to locate the information requested and provided a copy of the facility's policy entitled "Medication and Treatment Guidelines" documented, "General. Medications are administered in accordance with standards of practice and state specific and federal guidelines." Under "Medication and Treatment Orders" it documented, "Complete medication	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL		MB NO. 0938-03 (X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		Heating the second of the second	COMPLETED
		495011	B. WING	6099ZK	C 08/30/2018
NAME OF	PROVIDER OR SUPPLIE	RA N. IS STORY	s	TREET ADDRESS, CITY, STATE, ZIP CODE	00/30/2018
MANOR	CARE HEALTH SER	VICES-ALEXANDRIA		510 COLLINGWOOD ROAD LEXANDRIA, VA 22308	2027 (40)
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIC
F 658	Continued From p	page 42	F 658	8 c = 70 = x	
1		ite and time; name of patient;	1 030		
		cation; form, formula and route			
		dosage or strength, frequency,		- H	
		orders if applicable; directions the reason for use, diagnosis or		[n m
1		medication specific		1 1 2 1	A
	parameters, if app	blicable; name of the authorized			
- 8	practitioner giving	the order; signature of medical		0-	
	practitioner if the	order is written; and name, title,		65	
	the order."	he nurse transcribing/entering			
		proximately 12:25 p.m., ASM	1 1		
		aff member) # 1, the ASM # 2, director of clinical	1		
į.		# 3, quality assurance			5 1
3	consultant, were r	made aware of the findings.			-
1	When asked what	t standard of practice the			
	that they follow the	ws ASM # 2 and ASM # 3 stated e facility's policies and			
	procedures.	o racinty a policies and			
	No further informa	ation was provided prior to exit.			
	D -f				
	References:	n is used to relieve mild to			
		m headaches, muscle aches,			
	menstrual periods	, colds and sore throats,			1
	toothaches, backs	ches, and reactions to			
		s), and to reduce fever.			
		nay also be used to relieve the itis (arthritis caused by the			
1	breakdown of the	lining of the joints).			-
- 1	Acetaminophen is	in a class of medications called			
	analgesics (pain r	elievers) and antipyretics (fever			
	reducers). It works	s by changing the way the body			4.
		by cooling the body. This btained from the website:			27 12
		s dov/druginfo/meds/e681004 h			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	PLE CONSTRUCTION 3		TE SURVEY MPLETED C
	lum access	495011	B. WING _		90	/30/2018
	PROVIDER OR SUPPLIE CARE HEALTH SER	R IVICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP O 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 658	tmi.	page 43 sed to relieve moderate to	F 658	В		
	moderately seven extended-release used by people w medication to relia Tramadol is in a copiate (narcotic) at the way the brain pain. This inform website:			*2		
	lungs into your bloobtained from the	ough oxygen passes from your ood. This information was e website: nih.gov/medlineplus/respiratoryfa				
	the website:	information was obtained from nih.gov/medlineplus/anemia.html				
	blue, unhappy, mi Most of us feel thi short periods. Cli disorder in which or frustration inter or more. This info website:	hay be described as feeling sad, iserable, or down in the dumps. is way at one time or another for inical depression is a mood feelings of sadness, loss, anger, rifere with everyday life for weeks ormation was obtained from the us.gov/ency/article/003213.htm.				
	regulate the amou	ease in which the body cannot unt of sugar in the blood. This		1 5		

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Event ID: E2S311

Facility ID: VA0177

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DEPAR	TMENT OF HEALT	HAND HUMAN SERVICES	36	ATC - WE HAVE TO LOOK.	FORM APPROVED	
CENTE	RS FOR MEDICAR	RE & MEDICAID SERVICES			MB NO. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
_	in-	495011	B. WING _	40	C 08/30/2018	
NAME OF	PROVIDER OR SUPPLIE	R ST II WUMATTAL		STREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SER	VICES-ALEXANDRIA		1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 658	Continued From p	page 44	j F 658		vil.	
		nih.gov/medlineplus/ency/article/				
F 684 SS=D			F 684	F684		
	applies to all treat facility residents. I assessment of a chart residents recaccordance with practice, the compare plan, and the This REQUIREMI by: Based on resider facility document review, the facility received treatmer with professional comprehensive or in the survey same	of care a fundamental principle that iment and care provided to Based on the comprehensive resident, the facility must ensure eive treatment and care in professional standards of prehensive person-centered e residents' choices. ENT is not met as evidenced at interview, staff interview, review and clinical record e staff failed to ensure residents at and services in accordance estandards of practice and the are plan for one of 30 residents ple, Resident #41.		The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged dficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to ensure residents receive treatment and services in accordance with professional standards of practice and comprehensive care plans.		
•	blood pressure to parameters order administration, pri	ensure it was within the ed by the physician for or to administering blood on several occasions in		I . Corrective Action	11)	
	August 2018.			Resident #41's doctor was notified and order was clarified		
	The findings inclu	uo.				
	7/13/18 with diagr limited to muscle t and atrial fibrillation	admitted to the facility on noses that included but were not weakness, high blood pressure, on. Resident #41's most greent	li li	II. Identification All residents residing in the facility have the potential to be affected by the alleged deficient practice.		

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Facility ID: VA0177

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DA	<u>i, 0938-0391</u> TE SURVEY MPLETED
		495011	B. WING				C
MAMEGE	DOOMBED OF OURSE IES	493011	D. WING			08	/30/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-ALEXANDRIA		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 8C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETION DATE
F 684	admission assessme reference date) of coded as being comake daily decision 15 on the BIMS (Brexam. Review of Resident (physician order suphysician order suphysician on 8/6/18 "Lisinopril (1) 25 m qd (every day) for Hold for SBP (systethan 120." This ord Review of Resident (medication adminitisinopril was admis/29/18. There was blood pressures on Review of the vital care) in the electron pressures were obtained for the rerrecord. Resident #41's care documented in part disease related to experience effective the quarter. Interveper physician's order	nent with an ARD (assessment 7/20/18. Resident #41 was pnitively intact in the ability to as scoring 15 out of possible ief Interview for Mental Status) It #41's most recent POS mmary) signed by the part of the following order: g (milligrams) po (by mouth) fTN (high blood pressure), polic blood pressure) (2) less er was initiated on 8/1/18. It #41's August 2018 MAR estration record) revealed instered 8/1/18 through an o evidence of documented in the MAR. It will be a pressure with the following order: g (milligrams) po (by mouth) fTN (high blood pressure), polic blood pressure) (2) less er was initiated on 8/1/18. It #41's August 2018 MAR estration record) revealed instered 8/1/18 through an o evidence of documented in the MAR. It will be specified to the size of blood pressures being maining 22 days in the clinical diac care plan dated 7/17/18 to the following: "Cardiac drypertension Goal: Will be symptom management over notions: Administer medication	F	684	Licensed nurses will be reeducated to administer medications per doctor order. IV. Monitoring DON and/or designee will complete 5 random audits of EMAR/ETAR to ensure medications are administered per doctor orders. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or action. V. Date of Compliance 10/04/2018		

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DAT	(X3) DATE SURVEY COMPLETED		
		495011	B. WING			C 08/30/2018	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	/ICES-ALEXANDRIA	16	REET ADDRESS, CITY, STATE, ZIP CODE 10 COLLINGWOOD ROAD LEXANDRIA, VA 22308	1 06	30/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE	
F 684	conducted with Re often her blood pre #41 stated that she pressure checked supposed to be me On 8/30/18 at 11:2 conducted with LP Resident #41's nur process staff follow physician ordered predication, LPN # check the resident' blood pressure is co to be administered be held. LPN #2 st needs to be made	sident #41. When asked how assure was checked, Resident a barely gets her blood and was not sure if it was	F 684				
	administering blood parameters. When were documented, pressure should be When asked if Reswere documented confirmed that blood LPN #2 stated that been documented writer showed LPN notes. LPN #2 confor the missing date When asked how shall show administration of Lishe wouldn't know. Resident #41's blood administration of Lishe administration of Lishe wouldn't know.	e checked every time prior to d pressure medications with a asked where blood pressures LPN #2 stated that blood a documented on the MAR. Sident #41's blood pressures on her MAR, LPN #2 od pressures were missing. blood pressures may have in the nursing notes. This #2 Resident #41's nursing affirmed that blood pressures were not documented. The would know that Resident ares were checked prior to the isinopril, LPN #2 stated that when asked if she checks as pressure prior to the sinopril, LPN #2 did not ked if the order was followed,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011	(X2) MULTIPE A. BUILDING B. WING	PLE CONSTRUCTION	000	ATE SURVEY OMPLETED
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP (1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		8/30/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(XS) COMPLETION DATE
F 684	followed. When as Resident #41's red as the staff did not LPN #2 agreed that On 8/30/18 at 12:2 staff member) #1, DON (Director of Nouality Assurance the above concerns The facility policy it Treatment Adminis in part, the followin administered in ac standards of practifederal guidelines. No further informat In "Fundamentals Patricia A. Potter a Inc; Page 419. "The directing medical to obligated to follow believe the orders clients. Therefore one is found to be clarification from the (1) Lisinopril is use and heart failure. The form The National https://www.ncbi.nl T0010968/?report= (2) Systolic blood pcaused by your heart follow the caused by your heart failure as the staff of the caused by your heart failure as the staff of the caused by your heart failure as the staff of the caused by your heart failure as the caused by your heart failure as the caused by your heart failure as the caused by your heart failure.	sked if it was possible that ceived Lisinopril unnecessarily, of check the blood pressure, at it was possible. 25 p.m., ASM (administrative the administrator, ASM #2, the Nursing), and ASM #3, the consultant was made aware of ns. titled "Medication and stration Guidelines" documents ng: "Medications are cordance with professional tice and state specific and "" ation was presented prior to exit. of Nursing" 6th edition, 2005; and Anne Griffin Perry; Mosby, the physician is responsible for treatment. Nurses are physician's orders unless they are in error or would harm all orders must be assessed if the erroneous or harmful further the physician is necessary." ed to treat high blood pressure This information was obtained Institutes of Health. Ilm.nih.gov/pubmedhealth/PMH				

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		H AND HUMAN SERVIÇES E & MEDICAID SERVICES			FORM APPROVED	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
a linear		495011	B. WING	7 APR	C 08/30/2018	
NAME OF	PROVIDER OR SUPPLIEF	The second second	s	TREET ADDRESS, CITY, STATE, ZIP CODE	OGGGEOIG	
MANOR	CARE HEALTH SER	VICES-ALEXANDRIA		510 COLLINGWOOD ROAD NEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 684	defined as a systo This information w Institutes of Healtl https://www.nia.nil e.	lic pressure of less than 120." vas obtained from The National n. n.gov/health/high-blood-pressur	F 684	F693 The statement made of this plan of correction are not an admission to ar do not constitute an agreement with the alleged deficiencies herein. To		
F 693 SS=D	\$483.25(g)(4)-(5) (Includes naso-gaboth percutaneous end enteral fluids). Bascomprehensive as ensure that a resident and to prevent condition demonst clinically indicated resident; and \$483.25(g)(5) A remeans receives the services to restore and to prevent conincluding but not lindiarrhea, vomiting, abnormalities, and This REQUIREME by: Based on observed document review, was determined the treatment and services.	Enteral Nutrition stric and gastrostomy tubes, s endoscopic gastrostomy and oscopic jejunostomy, and sed on a resident's sessment, the facility must	F 693	remain in compliance with all Federa and State regulations, the center has taken or will take the actions set fort in the following plan of correction. The following POC constitutes the center's allegation of compliance suct that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to provide treatment and services for the management of tube feeding. I. Corrective Action Upon notification by the surveyor the Resident #35's HOB was not elevated resident was assessed with no finding and nurse and CNA were re-educated on ensuring that resident's HOB is elevated per resident's POC. II. Identification All residents receiving enteral theraging the facility have the potential to be affected by the alleged deficient practice.	th t	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495011	B. WING	i		l or	C 3/30/2018
7	PROVIDER OR SUPPLIER CARE HEALTH SERV			16	REET ADDRESS, CITY, STATE, ZIP CODE 10 COLLINGWOOD ROAD LEXANDRIA, VA 22308		3302310
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 693	Continued From pa	age 49	F	693	III. Systemic Changes		
	Resident #35's bed	= 0			Nursing will be re-educated on elevating the HOB for residents receiving TF per MD order and p of care.	olan	
	Resident #35 was 4/2/2009 and read diagnoses that inci-cerebrovascular di (difficulty swallowir status, and vascular most recent MDS (assessment was a ARD (assessment Resident #35 was cognitive function son the BIMS (brief exam). Resident # total dependence clocomotion, toiletin hygiene; and extertransfers. Resident (Swallowing/Nutritifeeding tube in plant Review of Resident (physician order sufollowing order: "Jehour. Start at 4 p.n. infused via gast (gast)	admitted to the facility on mitted on 7/29/2014 with luded but were not limited to sease (stroke), dysphagia my with NPO (nothing by mouth) ar dementia. Resident #35's (minimum data set) quarterly assessment with an reference date) of 7/11/18. coded as severely impaired in scoring 02 out of possible 15 interview for mental status #35 was coded as requiring on two of more staff with eating, my bathing, and personal risive assistance from staff with a #35 was coded in Section K onal Status) as having a ce. It #35's August 2018 POS immary) documented the evity 1.2 at 84 ml (milliliters) an and run until 1176 mls have astronomy tube) (1)."			IV. Monitoring DON and/or designee will visuall observe (5) residents on receiving to ensure that they are that HOB is elevated per MD order. These aux will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurant and Assessment Committee for reand action as appropriate. The committee will determine need at and/or actions. V. Date of Compliance 10/04/2018	g TF is dits id	
	plan dated 7/20/18	at #35's comprehensive care documented the following: tube r/t (related to) dysphagia by mouth)					

status...Interventions: elevate the head of bed

		H AND HUMAN SERVICES E & MEDICAID SERVICES		F 361 - 2 91 00 4 134 14	FORM	0: 09/14/2018 MAPPROVED 0: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DAT	TE SURVEY MPLETED
		495011	B. WING _		- 1	C /30/2018
NAME OF	PROVIDER OR SUPPLIER	20-11-W-11-11-11-11-11-11-11-11-11-11-11-1		STREET ADDRESS, CITY, STATE, ZIP CODE		130/2018
MANOR	CARE HEALTH SERV	/ICES-ALEXANDRIA	ĺ	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 693	Continuou i Torri p	_	F 69:	3	'n	
'	30-45 degrees dur	ing and 1 hour post feeding."		III II 3 ==		
	made of Resident	a.m., an observation was #35. Her tube feed on was on a r. Her head of bed was 0 degrees.	11			,
	medication pass w	:00 a.m. until 8:10 a.m., as observed with Resident vas also the only medication				
	Resident #35's doo	a.m., this writer knocked on or. The aide (CNA [certified #2 stated that she was lesident #35.		†		
	made of Resident a had been disconner room. Resident #3 completely flat. It if	a.m., an observation was #35. Her tube feed equipment octed and removed from her 15's head of bed was had not been 1 hour since the ast observed up and running.				
	On 8/29/18 at 8:49 bed continued to b	a.m., Resident #35's head of e completely flat.		(gd)(iii 177) (iii 17		
	On 8/29/18 at 9:28 observed up in her	a.m., Resident #35 was reclining chair.				
	conducted with LPI Resident #35's nur she took down Res 8/29/18. LPN #2 st but that it was whe morning medication provided ADL (active	7 a.m., an interview was N (licensed practical nurse) #2, se. LPN #2 was asked when sident #35's tube feed on ated she could not remember in she gave Resident #35 her ins and before the aide vities of daily living) care. LPN the head of bed should be	11.1		v	

77.7		AND HUMAN SERVICES			RINTED: 09/14/2018 FORM APPROVED MB NO. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495011	B. WING		C 08/30/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-ALEXANDRIA	161	REET ADDRESS, CITY, STATE, ZIP CODE 10 COLLINGWOOD ROAD .EXANDRIA, VA 22308	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 693	elevated for resider feeding and immed stated the head of the degrees. When as residents with tube bed elevated post for resident could aspire of bed should never feeding. When aske Resident #35's hear yesterday within the window, LPN #2 states. LPN #2 confin plan instructed the resident the care plan with the care	ge 51 Ints with a tube feed during the interpretation into the post feeding. LPN #2 Ded should be elevated 35-40 ked why it was important for feedings to have the head of eeding, LPN #2 stated that the rate. LPN #2 stated the head if she had noticed that do feed was completely flat to one hour post feeding atted that she was not aware of med that Resident #35's care nursing staff to keep the head 10-45 degrees one hour post atted that all nursing staff had plan. This writer informed LPN servations. LPN #2 confirmed was not followed if it was dent #35's head of bed bed to provide the head of bed to provide was dent head of bed to provide	F 693		

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care, but not all the way down as the resident

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION (2)	B NO. 0938-03 (3) DATE SURVEY COMPLETED	
- 1000		495011	B. WING _	1 11508	C 08/30/2018	
	PROVIDER OR SUPPLIE CARE HEALTH SER	VICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 693	could aspirate. Ch after care she wou	age 52 IA #1 stated that immediately Ild raise the head of bed back he nurse to restart the feeding.	F 69	3		
	brought in the faci #2 pointed out tha the head of bed st minimum of 30 mi completed. When to follow the facility ASM #2 stated tha	roximately 1 p.m., ASM #2 lity's enteral feed policy. ASM t the policy documented that hould be elevated for a nutes after feedings are asked if she expected her staff y policy or resident care plan, at she did not realize Resident cumented an hour and that the ne followed.	11	F695 The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will		
	(1) Gastronomy tu preferred route of in patients with a fi- system who requir The primary indica feeding is the prov- meet metabolic re- inadequate oral into obtained from The	tion was presented prior to exit. be- "Gastrostomy (PEG) is the feeding and nutritional support unctional gastrointestinal e long-term enteral nutrition. It in the feeding and parenteral rision of nutritional support to quirements for patients with take." This information was National Institutes of Health. Im.nih.gov/pmc/articles/PMC40		take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to provide respiratory care and services.		
F 695 SS=D	Respiratory/Trache CFR(s): 483.25(i)	eostomy Care and Suctioning	F 695			

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§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.

The facility must ensure that a resident who

needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered

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order.

I. Corrective Action

Resident #11's oxygen is now being administered per MD's

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION 3	(X3) DATE SURVE COMPLETED	
		495011	B. WING_		08	C /30/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-ALEXANDRIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRIDEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 695	care plan, the reside and 483.65 of this and 483.65 of this This REQUIREMENT by: Based on observarinterview, facility derecord review it was staff failed to provide services for one of sample, Resident # The facility staff fail 11's oxygen accord The findings included Resident # 11 was 02/28/18 and a readiagnoses that incher respiratory failure, (disorder (3), and disorder (3), and disorder # 11's moset), a quarterly assessment reference Resident # 11 as so interview for menta - 15, 15 - being cog decisions. Under service with the procedures and Procedu	ents' goals and preferences, subpart. NT is not met as evidenced tion, resident interview, staff cument review, and clinical statemined that the facility de respiratory care and 30 residents in the survey 11. The detal to administer Resident # ing to the physician's orders. The detal to the facility on dimission of 07/07/18 with aded but were not limited to (1), anemia, (2), depressive abetes mellitus (4). The treent MDS (minimum data desemble that an ARD ance date) of 06/07/18, coded coring a 15 on the brief atatus (BIMS) of a score of 0 mitively intact for making daily ection "O. Special Treatment, orgams" Resident # 69 was	F 69:	II. Identification All residents receiving oxyge therapy have the potential to affected. III. Systemic Changes Nursing staff have been reeducated on administration of oxygen at the prescribed rate IV. Monitoring DON and/or designee will autive (5) residents receiving respiratory care to ensure the oxygen is being administered prescribed rate weekly x four and then montit two. The results of these audivil be forwarded to the Qual Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or action. V. Date of Compliance 10/04/2018	be of e. dit at d at hly x dits lity	

STATEMENT	RS FOR MEDICAR FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	FORM APPROVED MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		495011	B. WING	a	C		
	PROVIDER OR SUPPLIE CARE HEALTH SER	R VICES-ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308				
(X4) ID PREFIX TAG	(EACH DEFICIENT	FATEMENT OF DEFICIENCIES CY 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 COMPLETION		
F 695	Continued From p	•	F 695		A		
	Resident # 11 revolution wheelchair watchi by nasal cannula concentrator. Obs	30 p.m., an observation of ealed she was sitting in her ng television, receiving oxygen connected to an oxygen servation of the oxygen flow	21		- 577 		
	meter on the oxyg	en concentrator revealed etween two and a half and	3 IIn				
	Resident # 11 reve wheelchair watchi by nasal cannula c concentrator. Obs meter on the oxyg	30 p.m., an observation of ealed her sitting in her ng television, receiving oxygen connected to an oxygen flow en concentrator revealed at two liters per minute.	10				
	11 dated "August :	an's order sheet) for Resident # 2018"documented, "07/07/18 vo liters per minute) via (by) tinuously."	-				
	dated 07/08/2018 risk for respiratory (chronic obstructiv "Interventions" it d	ve care plan for Resident # 11 documented, "Focus. Has/At impairment related to COPD re pulmonary disease." Under ocumented, "Administer redical doctor) orders. Date 18."					
	conducted with Reshe adjusted her	30 p.m., an interview was sident # 11. When asked if exygen Resident # 11 stated, in with my nurse and they did	go L Avett				
	On 08/29/18 at 11:	45 a.m., an interview was					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DAT	TE SURVEY
966		495011	B. WING	3			C /30/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-ALEXANDRIA		15	REET ADDRESS, CITY, STATE, ZIP CODE 110 COLLINGWOOD ROAD LEXANDRIA, VA 22308	>-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	=IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 695	conducted with ASM member) # 3, qualit When asked if she the previous day, or 11's nurse ASM # 3 oxygen with (LPN [I On 08/29/18 at 11:5 conducted with LPN 2. When asked if s room the previous of stated, "Yes 1 adjust supposed to be at the half. When asked oxygen is check LP do rounds, every two On 08/30/18 at 11:2 conducted with LPN 2. When asked to or rate of a resident's down and get eye lefter line should be to On 08/30/18 at app (administrative staff administrative staff administrator and A services and ASM # consultant, were many the further information obtained from the weight of the previous staff administrative staff administrative staff administrator and A services and ASM # consultant, were many the further information of the province of the previous staff administrator and A services and ASM # consultant, were many the previous staff administrator and A services and ASM # consultant, were many the previous staff administrator and A services and ASM # consultant, were many the previous staff administrator and A services and ASM # consultant, were many the previous staff administrator and A services and ASM # consultant, were many the previous staff administrator and A services and ASM # consultant, were many the previous staff administrator and ASM # consultant pre	M (administrative staff ty assurance consultant. entered Resident # 11's room n 08/28/18, with Resident # d stated, "Yes. I checked the licensed practical nurse] # 2)." 50 a.m., an interview was N (licensed practical nurse) # she entered Resident # 11's day, on 08/28/18 LPN # 2 ted the oxygen because it was two liters and it was at two and d how often a resident's N # stated, "I check it when I wo hours." 27 a.m., an interview was N (licensed practical nurse) # describe how to read the flow oxygen LPN # stated, "Knee evel with the concentrator, the through the middle of the ball." Proximately 12:25 p.m., ASM if member) # 1, the aSM # 2, director of clinical # 3, quality assurance ade aware of the findings. Ion was provided prior to exit.	F	695			

PRINTED: 09/14/2011 FORM APPROVEI OMB NO. 0938-039

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
	 	VICES-ALEXANDRIA	18	REET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308	08/30	V/2018
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRE C	(X5) COMPLETION DATE
\$\$=D	the website: https://www.nlm.n (3) Depression mablue, unhappy, mides of us feel this short periods. Clindisorder in which for frustration interfor more. This infowebsite: https://medlineplus. (4) A chronic disearegulate the amount information was other than the mount information was other than the facility must exprovided to resider consistent with prothe comprehensive and the residents' this REQUIREME by: Based on staff intered the facility staff failing assessment and at interventions for the	information was obtained from ih.gov/medlineplus/anemia.html by be described as feeling sad, serable, or down in the dumps. It is away at one time or another for a mood eelings of sadness, loss, anger, ere with everyday life for weeks rmation was obtained from the s.gov/ency/article/003213.htm. This is in which the body cannot ant of sugar in the blood. This obtained from the website: h.gov/medlineplus/ency/article/	F 697	F697 The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to provide a comprehensive pain management program and services. I. Corrective Action Resident #11's nurse was reeducated on completely assessing pain and offering non-pharmacological intervention prior. Resident #41's nurse was reeducated on completely assessing pain and offer non-pharmacological intervention prior.		

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Facility ID: VA0177

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495011	B. WING		Of	C V30/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-ALEXANDRIA	10	TREET ADDRESS, CITY, STATE, ZIP CODE 810 COLLINGWOOD ROAD ILEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 697	1a. The facility staff location of pain price Resident # 11's price 1b. The facility staff non-pharmacologic administration of Repain medication. 2. The facility staff pain assessment a non-pharmacologic administration of Tree 1b. The facility staff pain assessment a seessment a sees sees a see sees a see sees a sees a see see	f failed to document the or to the administration of a (as needed) pain medication. If failed to implement cal interventions prior to the esident # 11's prn (as needed) If failed to document a complete not failed to attempt cal interventions prior to the ramadol to Resident #41, on in July and August of 2018. If ailed to document a complete failed to document a complete	F 697	Resident #2's nurse was reeducated on offering non-pharmacological intervention pto administration of as needed medication. II. Identification All residents receiving pain medication have the potential to be affected. III. Systemic Changes Licensed nurses have been reeducated completing assessment per pain policy.		
	administration of lb four occasions in Ji The findings includ 1a. The facility staff location of pain pric Resident # 11's priof MAPAP [Tylenol] Resident # 11 was 02/28/18 and a readiagnoses that inclures piratory fallure, idisorder (5), and directly as (assessment references ident # 11's moset), a quarterly as (assessment references ident # 11 as so	e: If failed to document the or to the administration of (as needed) pain medication (1) and Tramadol (2). admitted to the facility on drnission of 07/07/18 with uded but were not limited to (3), anemia, (4), depressive		DON and/or designee will con random audits of five (5) resid to ensure that pain assessment completed and non-pharmacol intervention attempted prior to administration of as needed pa medication. These audits will I weekly x four (4) and monthly (2). The results of these audits forwarded to the Quality Assu Assessment Committee for revaction as appropriate. The com will determine need for further and/or actions.	ents chart was ogical in be done x two will be rance and riew and mittee	

PRINTED: 09/14/2018 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C **B. WING** 495011 08/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD **MANORCARE HEALTH SERVICES-ALEXANDRIA** ALEXANDRIA, VA 22308 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (XS) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY** F 697 Continued From page 58 F 697 V. Date of Compliance - 15, 15 - being cognitively intact for making daily decisions. Resident # 11 was coded as requiring 10/04/2018 limited to extensive assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 69 was coded for "C. Oxygen therapy." The POS (physician's order sheet) for Resident # 11 dated "August 2018" documented, "MAPAP 325MG (milligram) [Tylenol]. 2 (two) tabs (tablets) by mouth every day as needed for Pain - max (maximum) acetaminophen 3-4 GM (grams) daily - check daily total. 07/07/2018." "Tramadol 50 MG (milligram) tablet. 1 (one) tab (tablet) by mouth every 6 (six) hours as needed for pain. 07/07/2018 The MAR (medication administration record) for Resident # 11, dated "August 2018" documented the above physician's orders. The August 2018 MAR falled to evidence the administration of MAPAP. Further review of the August MAR revealed Tramadol 50 MG was administered to Resident #11, on 08/01/18, 08/06/18, 08/12/18 and 08/14/18. Further review of the MAR failed to evidence documentation of Resident # 11's location of pain. Review of "Progress Notes" for Resident # 11 dated 08/01/18 through 08/29/18 failed to evidence documentation of Resident # 11's pain

08/14/18.

2

location prior to the administration of prn Tramadol on 08/01/18, 08/06/18, 08/12/18 and

On 08/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) #

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED	
		495011	8. WING		l na	/30/2018	
	PROVIDER OR SUPPLIE CARE HEALTH SER	R VICES-ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308				
(X4) ID PREFIX TAG	(EACH DEFICIEN	ITATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE	
F 697	LPN # 2 was ask staff follows for the needed) pain me "Asked the patier worse, where the MAR and che they can have, ging back and cheer andication worked After I give it, I do the time, the date medication, pain nurse's notes the medication and a resident's location LPN # 2 stated, "# 2 was asked to 2018 and the Protough 08/29/18 if the location of foocumented, LPI if a complete pair Resident # 11, LF On 08/30/18 at a (administrative st	ed to describe the procedure ne administration of pm (as dications. LPN # 2 stated, nt the level of pain 1-10 ten being pain is, when it started. Go to nck the prn pain medication that we the one I'm supposed to give, nck them after 30 min to see if the ed and get another pain level. Incument on the back of the MAR re, my initials, type of pain level, and document in the time it was given, type of mount. "When asked if the n of their pain is documented, Yes, in the nurse's notes." LPN review the August MAR dated gress Notes dated 08/01/18 for Resident # 11. When asked resident # 11's pain was M # 2 stated, "No." When asked h assessment was completed for PN # 2 stated, "No."	F 697				
	services and ASN consultant, were	I ASM # 2, director of clinical I # 3, quality assurance made aware of the findings. ation was provided prior to exit.					
	References: (1) Acetaminophe moderate pain from menstrual period toothaches, back vaccinations (sho	en is used to relieve mild to om headaches, muscle aches, s, colds and sore throats, aches, and reactions to ts), and to reduce fever.					

PRINTED: 09/14/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES AB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 495011 B. WING 08/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD MANORCARE HEALTH SERVICES-ALEXANDRIA **ALEXANDRIA, VA 22308** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) PLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE **DEFICIENCY**) F 697 Continued From page 60 F 697 pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.h tml. (2) Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.ht ml. (3) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfa ilure.html. (4) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html

(5) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger,

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA			D. 11111	1510	EET ADDRESS, CITY, STATE, ZIP CODE D COLLINGWOOD ROAD EXANDRIA, VA 22308	08/	/30/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697	or more. This info website: https://medlineplu (6) A chronic dise- regulate the amou information was o https://www.nlm.n 001214.htm. 1b. The facility sta- non-pharmacolog administration of li- pain medication. The POS (physici 11 dated "August 325MG (milligram by mouth every da (maximum) aceta - check daily total MG (milligram) tal	page 61 riere with everyday life for weeks ormation was obtained from the is.gov/ency/article/003213.htm. rase in which the body cannot unt of sugar in the blood. This obtained from the website: nih.gov/medlineplus/ency/article/aff failed to implement pical interventions prior to the Resident # 11's prn (as needed) ian's order sheet) for Resident # 2018" documented, "MAPAP n) [Tylenol]. 2 (two) tabs (tablets) ay as needed for Pain - max iminophen 3-4 GM (grams) daily 1. 07/07/2018." "Tramadol 50 blet. 1 (one) tab (tablet) by x) hours as needed for pain.	F6	97			
	Resident # 11, da the above physici. MAR failed to evid MAPAP. Further r revealed Tramado Resident #11, on and 08/14/18. Fu to evidence docur non-pharmacolog	ation administration record) for ted "August 2018" documented an's orders. The August 2018 dence the administration of review of the August MAR of 50 MG was administered to 08/01/18, 08/06/18, 08/12/18 or review of the MAR failed mentation of jical interventions prior to the Resident # 11's pm (as needed)					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/14/2018 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495011 B. WING 08/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD MANORCARE HEALTH SERVICES-ALEXANDRIA **ALEXANDRIA, VA 22308** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) F 697 Continued From page 62 F 697 Review of "Progress Notes" for Resident # 11 dated 08/01/18 through 08/29/18 failed to evidence documentation of non-pharmacological interventions prior to the administration of Resident # 11's as needed Tramadol on 08/01/18. 08/06/18, and 08/12/18 and on 08/14/18. The comprehensive care plan for Resident # 11 dated 07/08/2018 documented, "Focus. At risk for pain related to immobility, gout, neuropathy." Under "Interventions" it documented, "Implement non-pharmacological interventions such as music, watching TV or positioning to assist with pain and monitor for effectiveness. Date initiated: 07/09/2018." On 08/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) # When asked to describe the procedure staff follow for the implementation of non-pharmacological interventions prior to the administration of prn (as needed) pain medications, LPN # 2 stated. "Non-pharmacological interventions should it be attempted prior to giving the pain medication." When asked where it is documented that the non-pharmacological interventions were attempted, LPN # 2 stated, "In the progress notes." LPN # 2 was asked to review the August MAR and progress notes dated for Resident # 11 dated 08/01/18 through 08/29/18. When asked if there was documentation that non-pharmacological interventions were attempted when Resident # 11 was administered Tramadol on 08/01/18, 08/06/18, 08/12/18 and on

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08/14/18, LPN # 2 stated no. When asked if

non-pharmacological interventions, being attempted could you say it was done, LPN # 2

there was no documentation of

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Facility ID: VA0177

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PRINTED: 09/14/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVEC CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ C 495011 B. WING 08/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD MANORCARE HEALTH SERVICES-ALEXANDRIA **ALEXANDRIA, VA 22308** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) (D PREFIX (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 697 Continued From page 63 F 697 stated no. On 08/30/18 at approximately 12:25 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit. References: (1) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches. menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.h tml. (2) Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need

medication to relieve pain around-the-clock.

Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the

https://medlineplus.gov/druginfo/meds/a695011.ht

PRINTED: 09/14/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495011 **B. WING** 08/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD MANORCARE HEALTH SERVICES-ALEXANDRIA **ALEXANDRIA, VA 22308 SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION מו (XS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) F 697 Continued From page 64 F 697 2. The facility staff failed to document a complete pain assessment and failed to attempt non-pharmacological interventions prior to the administration of Tramadol to Resident #41, on several occasions in July and August of 2018. Resident #41 was admitted to the facility on 7/13/18 with diagnoses that included but were not limited to muscle weakness, high blood pressure. and atrial fibrillation. Resident #41's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/20/18. Resident #41 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #41's July and August 2018 POS (physician order summary) revealed the following order: "Tramadol 50 mg (milligrams) 1 tab (tablet) by mouth every 8 hours as needed for pain." Review of Resident #41's July 2018 MAR (medication administration record) revealed that Resident #41 received Tramadol on the following dates: 7/18/18 at 1 p.m., 7/19/18 at 9 a.m., 7/20/18 at 9 a.m., 7/23/18 at 9:00 a.m., 7/24/18 at 8:00 a.m., and 7/27/18 at 10:00 p.m.

On 7/27/18, there was no pain scale, follow up pain scale/evaluation or location of pain

Review of Resident #41's July nursing notes

documented on the back of the MAR. There was no evidence that non-pharmacological pain relief interventions were attempted prior to the administration of Tramadol for all above dates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES					OMB NO) <u>. 0938-039</u> 1
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	-1		TE SURVEY MPLETED
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NAME OF	NAME OF PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, ST	ATE, ZIP CODE		13012010
MANOR	CARE HEALTH SERV	/ICES-ALEXANDRIA			o collingwood Roa Exandria, va 2230	THE PLANT OF THE PARTY OF THE P		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLA (EACH CORRECTIVE CROSS-REFERENCE DEFI	E ACTION SHOL	JLD BE	(XS) COMPLETION DATE
F 697	failed to evidence interventions were administration of T There were no nur Resident #41's pai Review of Resident (medication admin Resident #41 rece	that non-pharmacological pain attempted prior to the framadol on the above dates. rsing notes that addressed in on 7/27/18. ht #41's August 2018 MAR histration record) revealed that sived Tramadol on the following 18, 8/11/18, 8/18/18, 8/20/18,	Fe	697			F3	
	was no evidence of documented on the There was no documented prince attempted prince were attempted prince a	8, 8/18/18 and 8/22/18 there of the location of pain e back of the August MAR. urnented evidence that cal pain relief interventions ior to the administration of pove dates. August nursing a found in the clinical record tt #41's pain for the above						
	7/13/18 document "Implement non-ph such as music, pos	nt #41's pain care plan dated ed the following intervention: harmacological interventions sitioning, or OOB (out of bed) dichair to assist with pain and veness."						
	conducted with Re tried other things s etc. prior to giving	a.m., an interview was esident #41. When asked if staff such a hot therapy, massage a pm pain medication, ed that she was just given a pill.						
1	conducted with LP	7 a.m., an interview was N (licensed practical nurse) #2, rse. When asked about the						

STATEMEN AND PLAN	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(XS) DAT	TE SURVEY MPLETED	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-ALEXANDRIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE	
F 697	needed) pain menurses should be pain on a scale frossible pain), are needed) pain menused what pain menures that once pain would go back minutes. LPN #2 should be docum When asked what of the MAR, LPN initials, type of measked if location of assessment, LPN that location of pa#2 stated that if the should be should be docum when asked what of the MAR, LPN initials, type of measked if location of pa#2 stated that if the should be shou	page 66 bws when administering prn (as dications, LPN #2 stated that asking the patient their level of om 1-10 (10 being the worst ad then go check the prn (as dications. LPN #2 stated that a pain level, when it started, and adications she can give. LPN #2 pain medication is administered, and reassess pain after 30 stated that this information ented on the back of the MAR. It was documented on the back #2 stated, "Time, date, my edication, pain level." When of pain was part of the pain I #2 confirmed that it was and the should be documented. LPN the pain assessment was not on AR, that it may be documented	F 697				
	in a nursing note. interventions for prior to administe stated that she we #2 stated that you resident if non-phinterventions wou resident may also non-pharmacolog least offered prior LPN #2 stated, "Y before giving med documented anyw non-pharmacolog attempted or offer information should note. When aske attempt non-pharmacologham in the work when a work when we work when a work when we work when a work when a work when we wor	When asked if other ain relief should be attempted, ring pain medications, LPN #2 buld attempt sometimes. LPN to could tell by talking to the armacological pain relief ld work. LPN #2 stated that the refuse. When asked if it al interventions should be at to giving prin pain medications, les, it should be done each time lication." When asked if it was where in the clinical record that ical interventions were red, LPN #2 stated that that did be documented in a progress d why it was important to macological pain relief					

PRINTED: 09/14/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION (DENTIFICATION NUMBER: COMPLETED A. BUILDING C 495011 B. WING 08/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD MANORCARE HEALTH SERVICES-ALEXANDRIA **ALEXANDRIA, VA 22308 SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PAFFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 697 Continued From page 67 F 697 medications, LPN #2 stated that the pain could be managed by other means. LPN #2 confirmed the above concerns. LPN #2 stated that Resident #41 requested her pain medication and that the resident knew what she wanted. When asked again if non-pharmacological interventions should be offered or attempted before any prn, pain medication is given, LPN #2 stated yes. On 8/30/18 at 12:25 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the Quality Assurance Consultant was made aware of the above concerns. (1) Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197. 3. The facility staff failed to document a complete pain assessment and attempt non-pharmacological interventions prior to the administration of Ibuprofen to Resident #2, on four occasions in July and August of 2018. Resident #2 was admitted to the facility on 5/17/18 with diagnoses that included but were not limited to type two diabetes mellitus, hypothyroidism, post stroke, and back pain with

spinal stenosis. Resident #2's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/24/18. Resident #2 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #2's was coded as requiring limited assistance from

PRINTED: 09/14/2018 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495011 B. WING 08/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1610 COLLINGWOOD ROAD **MANORCARE HEALTH SERVICES-ALEXANDRIA ALEXANDRIA, VA 22308** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION m (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) Continued From page 68 F 697 one staff member with locomotion on and off the unit; extensive assistance with one staff member with transfers, personal hygiene, and bathing; and total dependence on staff with dressing. Review of Resident #2's July and August 2018 POS (physician order summary) documented the following order: "Ibuprofen 200 mg (milligrams), take two tablets po (by mouth) q (every) 8 hours pm (as needed) headache." Review of Resident #2's July and August 2018 MAR (medication administration record) revealed that she received Ibuprofen on the following dates and times: 7/25/18 at 3:00 p.m. and 7/31/18 at 12:00 p.m., 8/3/18 at 1:00 a.m., and 8/25/18 at 3:30 a.m. Review of the July and August 2018 MARS failed to evidence pain scales for the above dates follow up pain assessments and non-pharmacological interventions attempted prior to the administration of Ibuprofen. Review of Resident #2's nursing notes revealed a note dated 8/25/18 that documented in part, the following: "Resident c/o (complaints) pain 3/10. Ibuprofen administered 400 mg resulting in pain 0/10..." This note did not address non-pharmacological interventions attempted

dates.

prior to the administration of the Ibuprofen.

No other notes could be found in the clinical record regarding Resident #2's pain on the above

Resident #2's pain care plan dated 5/17/18 documented the following intervention: "Implement non-pharmacological interventions

PRINTED: 09/14/2018 **DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES IB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING C 495011 B: WING 08/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD MANORCARE HEALTH SERVICES-ALEXANDRIA **ALEXANDRIA, VA 22308** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (3(5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE MPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 697 Continued From page 69 F 697 such as music, positioning or other activities of choice to assist with pain and monitor for effectiveness." On 8/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #41's nurse. When asked about the process staff follows when administering prn (as needed) pain medications, LPN #2 stated that nurses should be asking the patient their level of pain on a scale from 1-10 (10 being the worst possible pain), and then go check the prn (as needed) pain medications. LPN #2 stated that she would ask the pain level, when it started, and see what pain medications she can give. LPN #2 stated that once pain medication is administered. she would go back and reassess pain after 30 minutes. LPN #2 stated that this information should be documented on the back of the MAR. When asked what was documented on the back of the MAR, LPN #2 stated, "Time, date, my initials, type of medication, pain level." When asked if location of pain was part of the pain assessment, LPN #2 confirmed that it was and that location of pain should be documented. LPN #2 stated that if the pain assessment was not on the back of the MAR, that it may be documented in a nursing note. When asked if other interventions for pain relief should be attempted, prior to administering pain medications, LPN #2 stated that she would attempt sometimes. LPN

#2 stated that you could tell by talking to the resident if non-pharmacological pain relief interventions would work. LPN #2 stated that the resident may also refuse. When asked if non-pharmacological interventions should be at least offered prior to giving pm pain medications, LPN #2 stated, "Yes, it should be done each time before giving medication." When asked if it was

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED
1.000 10	671	495011	B. WING		08	/30/2018
	PROVIDER OR SUPPLIER CARE HEALTH SER	/ICES-ALEXANDRIA		STREET AODRESS, CITY, STATE, ZIP O 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		-137
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
	documented anyw non-pharmacologi attempted or offen information should note. When asked attempt non-pharm interventions prior medications, LPN managed by other above concerns. On 8/30/18 at 12:2 staff member) #1, DON (Director of N Quality Assurance the above concern (1) Ibuprofen is a r drug used to treat information was ot Institutes of Health https://www.ncbi.nt T0010648/7reports Drug Regimen is F CFR(s): 483.45(d) Unnecessity of the state	there in the clinical record that cal interventions were ed, LPN #2 stated that that le documented in a progress d why it was important to nacological pain relief to administering pain #2 stated that the pain could be means. LPN #2 confirmed the means. LPN #2 confirmed the stated that the pain could be means. LPN #2 confirmed the consultant was made aware of s. In Consultant was made aware of s.	F 757	The statements made on of correction are not an admission to and do not constitute an agreement the alleged deficiencies. To remain in compliance Federal and State regula center has taken or will actions set forth in the federal plan of correction. The federal plan of correction in the federal and state remained that all alleged deficiency that all alleged deficiency have been or will be continued that indicated. It is the practice of the federal residents are unnecessary medication.	with herein. e with all stions, the take the following following ter's e such sies Cited rected by facility to free of	
	unnecessary drugs drug when used-	ag regimen must be free from S. An unnecessary drug is any scessive dose (including apy); or	- 2	Resident #41's doctor we called and notified that obtained per MD's order.		1
		excessive duration; or		II. Identification Residents who has para	umeters	
	§483.45(d)(3) With	out adequate monitoring; or		for medication adminis		

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

Event ID: E2S311

Facility ID: VA0177

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495011	B. WING			08	C /30/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-ALEXANDRIA		151	REET ADDRESS, CITY, STATE, ZIP CODE 10 COLLINGWOOD ROAD EXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 757	§483.45(d)(4) With use; or §483.45(d)(5) In the consequences which reduced or discontile \$483.45(d)(6) Any stated in paragraph section. This REQUIREMED by: Based on resident facility document review, it was deterted to ensure a resident medications for one sample, Resident #1's block order on several occupance of the findings included Resident #41's block order on several occupance and atrial fibrillation MDS (minimum data admission assessing reference date) of a coded as being cogmake daily decision	out adequate indications for its e presence of adverse ch indicate the dose should be nued; or combinations of the reasons is (d)(1) through (5) of this NT is not met as evidenced interview, staff interview, eview and clinical record mined that facility staff failed at was free from unnecessary of 30 residents in the survey e41. ministered Lisinopril (blood in) (1) without checking od pressure per physician's ecasions (22 times) in August	F7	757	Licensed nurses were reeducated to administer medication per MD order. IV. Monitoring DON and/or designee will complete audit of five residents with medication parameters to ensure BP are obtained and medication administer as order weekly x four (4) and then monthly x two (2). The results these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action will be taken as appropriate. The committee will determine need for further audits and/or actions. V. Date of Compliance 10/04/2018	ed of	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011			PLE CONSTRUCTION 3	(X3) t	DATE SURVEY COMPLETED		
	PROVIDER OR SUPPLIE	RVICES-ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
	Review of Reside (physician order: physician on 8/6/ "Lisinopril 25 mg (every day) for H for SBP (systolic 120." This order: Review of Reside (medication admit Lisinopril was adi 8/29/18. There we blood pressures described to the vita care) in the electropressures were of following dates: 8/12/18, 8/19/18, There was no eviromaining 22 day Resident #41's care documented in particular disease related to experience effect the quarter. Interview per physician's or On 8/29/18 at 9:5 conducted with Roften her blood pressure checked supposed to be marked.	ent #41's most recent POS summary) signed by the 18, revealed the following order: (milligrams) po (by mouth) qd TN (high blood pressure), Hold blood pressure) (2) less than was initiated on 8/1/18. ent #41's August 2018 MAR inistration record) revealed ministered 8/1/18 through was no evidence of documented on the MAR. al sign tab on PCC (point click ronic record, revealed blood obtained and documented on the 1/1/18, 8/2/18, 8/3/18, 8/5/18, and 8/26/18. dence of blood pressures for the is in the clinical record. ardiac care plan dated 7/17/18 art, the following: "Cardiac of Hypertension Goal: Will live symptom management over rentions: Administer medication ider." 7 a.m., an interview was esident #41. When asked how ressure was checked, Resident he barely gets her blood and was not sure if it was	F 757				
	conducted with Li	27 a.m., an Interview was PN (licensed practical nurse) #2,					

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

PRINTED: 09/14/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		222 Land		OMB NO	0, 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 485011	(X2) MUL A. BUILD B. WING	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C 08/30/2018		
NAME OF	PROVIDER OR SUPPLIER	100011		CTOCCT ADDDECS	CITY STATE 710 CODE	1 00	5/30/2016	
	CARE HEALTH SERV	ICES-ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTIVE ACTION SHOP PERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 757	process staff follow physician ordered predication, LPN #2 check the resident' blood pressure is to be administered be held. LPN #2 staneeds to be made medication is held. pressure should be administering blood parameters. When were documented, pressure should be When asked if Reswere documented confirmed that blood LPN #2 stated that been documented writer showed LPN notes. LPN #2 confor the missing date when asked how s #41's blood pressure administration of Li she wouldn't know. Resident #41's blood administration of Li answer. When ask LPN #2 stated that followed. When ask Resident #41's recast the staff did not LPN #2 agreed that On 8/30/18 at 12:2	se. When asked about the is when a resident has parameters for blood pressure 2 stated that nursing should is blood pressure, and if the out of range for the medication in them the medication ated, "The physician also aware if the blood pressure." LPN #2 confirmed that blood is checked every time prior to dispressure medications with asked where blood pressures LPN #2 stated that blood is documented on the MAR. In ident #41's blood pressures on her MAR, LPN #2 and pressures were missing. In the nursing notes. This #2 Resident #41 is nursing firmed that blood pressures as were not documented. The would know that Resident res were checked prior to the sinopril, LPN #2 stated that When asked if she checks of pressure prior to the sinopril, LPN #2 did not asked if the order was followed, the above order was not ked if it was possible that eived Lisinopril unnecessarily, check the blood pressure,	F7	67				

DON (Director of Nursing), and ASM #3, the

PRINTED: 09/14/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING_ 495011 R WING 08/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD **MANORCARE HEALTH SERVICES-ALEXANDRIA ALEXANDRIA, VA 22308** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE MPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 757 Continued From page 74 F 757 Quality Assurance Consultant was made aware of the above concerns. A policy could not be provided regarding the above concerns. (1) Lisinopril is used to treat high blood pressure and heart failure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0010968/?report=details. (2) Systolic blood pressure "is the pressure caused by your heart contracting and pushing out blood. Normal blood pressure for adults is F812 defined as a systolic pressure of less than 120." This information was obtained from The National Institutes of Health. The statement made on this plan of https://www.nia.nih.gov/health/high-blood-pressur correction are not an admission to and do not constitute an agreement F 812 Food Procurement, Store/Prepare/Serve-Sanitary F 812 with the alleged deficiencies herein. CFR(s): 483.60(i)(1)(2) SS=E To remain in compliance with all Federal and State regulations, the §483.60(i) Food safety requirements. center has taken or will take the The facility must actions set forth in the following plan of correction. The following §483.60(i)(1) - Procure food from sources POC constitutes the center's approved or considered satisfactory by federal. allegation of compliance such that all state or local authorities. alleged deficiencies cited have been (i) This may include food items obtained directly from local producers, subject to applicable State or will be corrected by the date and local laws or regulations. indicated.

(ii) This provision does not prohibit or prevent

gardens, subject to compliance with applicable

facilities from using produce grown in facility

safe growing and food-handling practices.

(iii) This provision does not preclude residents

manner.

It is the practice of the facility to

Serve and store food in a sanitary

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	42 FUR MEDICARE	& MEDICAID SERVICES				<u>)MB NO</u>	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO		E CONSTRUCTION	(X3) DA1	TE SURVEY
		495011	B. WING				C /30/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	30/2010
				ı	510 COLLINGWOOD ROAD		
MANOR	CARE HEALTH SERV	ICES-ALEXANDRIA			LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X8) COMPLETION DATE
F 812		•	F	312	I. Corrective Action		
	trom consuming to	ods not procured by the facility.					Į.
	8492 60(IVO) C+	e, prepare, distribute and			OSM #4 was immediately re-		
		dance with professional		ı	educated on serving and storing		
	standards for food				food sanitary manner. The food		
		NT is not met as evidenced			processor was cleaned and garlic		1
	by:	The first mot all dynamics			was discarded.		
		tion, staff interview, and facility					
		t was determined that the			II. Identification		
	facility staff failed to	serve and store food in a					
	sanitary manner.				All residents in the facility have the	е	
i .				ł	potential to be affected by the		
		ed to ensure a food			alleged deficient practice.		
		nd ready for use was free of					
		de the bowl and failed to					
	while being stored i	opped garlic was covered n the walk-in refrigerator.			III. Systemic Changes		
.		_			Dietary staff will be re-educated		ı
	The findings include	e:		į	on serving and storing food in a		
	00000000				sanitary manner.		
	On 08/28/18 at app	roximately 10:55 a.m., an			 ,		
		kitchen was conducted with ember) # 4, dietary manager.		1			ŀ
	An observation of ti	he food processor revealed it			IV. Monitoring		
		ting on the kitchen preparation			Food Service Director and/or design	mae	Į.
		if the food processor was		1		-	•
	Linea cashina the t	for use OSM # 4 stated yes. op of the food processor, bowl			will observe food storage to ensur		
	an observation of the	ne inside of the bowl revealed			food is served and stored in sanita	гу	
		of the bowi. When OSM # 4		. [manner weekly x four (4)		İ
ļ		ate the amount of water in the			and then monthly x two (2).		
		ed, "Looks like a couple of			The results of these audits will be		
		M # 4 immediately removed all		- 1	forwarded to the Quality Assurance		
	the parts of the food	processor and sent them to			and Assessment Committee for re	view	
	the sink to be wash				and action as appropriate. The		ļ
					committee will determine the need	I for	ľ
		ne walk-in refrigerator with an uncovered Styrofoam bowl			further audits and/or actions.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011		(X2) MULTIPLE A. BUILDING B. WING			(XS) DATE SURVEY COMPLETED C 08/30/2018		
	PROVIDER OR SUPPLIE CARE HEALTH SER	R WICES-ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE	
F 812	on a shelf contair chopped garlic. Covered" and imm walk-in refrigerate. The facility's polic Procedure-Blend. "6. Air dry." The facility's polic documented in perioducts in Nationapproved sanitary in food quality placontents and date. On 08/29/18 at a (administrative stadministrative stadministrative and services and ASM consultant, were the No further informatical processions.	ning approximately half a cup of DSM # 4 stated, "This should be nediately removed it from the property of the	F 812	F 842 The statement made on the correction are not an admand do not constitute an awith the alleged deficient herein. To remain in correction and States	nission to agreement cies apliance		
SS=D	§483.20(f)(5) Res (i) A facility may n resident-identifiat (ii) The facility ma resident-identifiat accordance with a agrees not to use except to the exte to do so. §483.70(i) Medica §483.70(i)(1) In a	y release information that is ble to an agent only in a contract under which the agent or disclose the information ant the facility itself is permitted		regulations, the center ha will take the actions set f following plan of correct following POC constitute center's allegation of con such that all alleged deficited have been or will be corrected by the date ind. It is the practice of the fa Ensure accurate and com resident records.	orth in the ion. The es the appliance ciencies e icated.		

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

Event ID: E25311

Facility D: VA0177

If continuation sheet Page 77 of 83



DEPARTMENT OF HEALTH AND HUMAN SERVICES

		A MEDICAID SERVICES	T			, uase-usas
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED C
		495011	B. WING		OS	/30/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	100/2010
MANOR	CARE HEALTH SERV	ICES-ALEXANDRIA		1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		2:
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		JLD BE	(X5) COMPLETION DATE
F 842	Communication pr	_	F B4	I. Corrective Action		
	must maintain med that are-	dical records on each resident		Resident #13's kardex was		
	(i) Complete;			immediately updated to reflect		
	(ii) Accurately docu (iii) Readily access			resident code status.		
	(iv) Systematically			II. Identification		1
	8483.70(i)(2) The f	acility must keep confidential		All residents residing in the facil	ity	
		tained in the resident's records.		have the potential to be affected	by	1
	regardless of the forecords, except wh	orm or storage method of the nen release is-	1	the alleged deficient practice.		
		ere permitted by applicable law;		III. Systemic Changes		
	(ii) Required by Lat	w, payment, or health care		Licensed nurses were re-educate		1
		mitted by and in compliance		timely updating resident's karde		
	with 45 CFR 164.5			new information. House audit w		
		th activities, reporting of abuse,		completed to ensure consistency	/ of	
8		ic violence, health oversight		code documentation.		
	law enforcement p	nd administrative proceedings, urposes, organ donation		II .		
	medical examiners	n purposes, or to coroners, s, funeral directors, and to avert health or safety as permitted		IV. Monitoring		
		ce with 45 CFR 164.512.		DON and/or designee will con	nplete	
	o, and in complian			audit of five residents kardex	.0	
	§483.70(i)(3) The f	acility must safeguard medical		ensure it has been updated wit	h new	
ļ.		against loss, destruction, or		information weekly x four (4)	and	
	unauthorized use.			then monthly x two (2).		
	0.400 70(h(4) 44- di			The results of these audits wil	be	
	§483.70(i)(4) Medic	cal records must be retained		forwarded to the Quality Assu		
	11.4.4	ne required by State law; or		and Assessment Committee for		
	(ii) Five years from	the date of discharge when	1	review and action as appropria		
		ment in State law; or		The committee will determine		1
		years after a resident reaches		for further audits and/or action	ıS.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495011		(X2) MULTIPLE A. BUILDING _ B. WING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/30/2018		
	PROVIDER OR SUPPLIE	R IVICES-ALEXANDRIA	15	REET ADDRESS, CITY, STATE, ZIP CODE 110 COLLINGWOOD ROAD LEXANDRIA, VA 22308	AGE V. II	30/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	COMPLETION DATE
F 842	§483.70(i)(5) The (i) Sufficient inform (ii) A record of the (iii) The compreh provided; (iv) The results of and resident revideterminations of (v) Physician's, nu professional's profess	medical record must containmation to identify the resident; a resident's assessments; ensive plan of care and services if any preadmission screening ew evaluations and onducted by the State; urse's, and other licensed agress notes; and adiology and other diagnostic as required under §483.50. ENT is not met as evidenced evation, staff Interview, and clinical eas determined the facility staff a complete and accurate clinical 30 residents in the survey #13.		V. Date of Compliance 10/04/2018		
; ;	Resuscitate" (DN	ailed to ensure the "Do Not R) status of Resident #13 was d into the Task/Kardex section nedical record.	22			
	The findings inclu	de:	ī			
	1/2/15 with diagnormited to: Alzhein swallowing, adult muscle wasting, to (A contracture de stretchy (elastic) nonstretchy (inelamakes it hard to s	s admitted to the facility on oses that included but were not ner's disease, difficulty failure to thrive (weight loss, weakness) (1), and contractures velops when the normally issues are replaced by isstic) fiber-like tissue. This tissue attent the area and prevents				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER 495011		(X2) MULTIPLE CONSTRUCTION A SUILDING		00	TE SURVEY MPLETED C	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICE	I	ST 15	REET ADDRESS, CITY, STATE, ZIP 10 COLLINGWOOD ROAD LEXANDRIA, VA 22308		/30/2018	
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	IN SHOULD BE E APPROPRIATE	COMPLETION DATE	
assessment, a quart assessment reference resident as having mediated by ounderstanding other requiring total assists staff members for be locomotion on and outleting, bathing, and Section O - Special Programs, the reside hospice care during: A review of Resident revealed physicians documenting, "Do Not Transfer-Hospice." A review of Resident documented the "Du Order" that was sign responsible represers A review of the comp 9/4/17, with a most redocumented in part, due to senile degenerat, "Honor advance documents that allow decisions about end-	es (minimum data set) lerly assessment, with an ce date of 6/10/18, coded the o ability in making others, as well as rarely/never s. The resident was coded as ance of at least one or more ad mobility, transfers, off the unit, dressing, eating, d personal hygiene. In Treatments, Procedures and ent was coded as requiring the look back period. If #13's clinical record order date of order ot Resuscitate-Do Not If #13's clinical record order date of order ot Resuscitate by Resident #13's entative on 2/12/18. Orehensive care plan dated recent revision on 3/27/18, "Focus: Hospice care need oration of the brain". The of this focus documented in	F 842				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION	OMB N	(X3) DATE SURVEY COMPLETED C	
MANE OF		495011	B. WING _	- 100-		8/30/2018	
NAME OF	PROVIDER OR SUPPLIER	TE 35 10 5 11		STREET ADDRESS, CITY, STATE, ZIP CX	DDE		
MANOR	CARE HEALTH SERV	HEREICAN DESCRIPTION IN		1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	MUST BE PRECEDED BY FULL DOCERY		TX (EACH CORRECTIVE ACTION SHOULD BE		
	On 08/30/18 at 11: #3 was asked how resident's code state "DNR" (do not are marked with a the front of the resils copied onto redis a DNR. Behind signed and dated "Order". RN #3 was regarding a resider Task/Kardex section record, RN #3 state time, RN #3 review record of Resident documentation in the documentation in the documented that R full code. RN #3 fix updating Resident and the correct code state confirming this per Resident's clinical and must be a "system Click Care (PCC) (system the facility and RN #3 stated she was resident's informatically during began randomly chito see if their record During this random inaccuracies regard She stated she would be stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record She stated she would resident to see if their record she she was she she was she she was she she was she she was she she she was she she she she she she she she she sh	age 80 23 a.m., RN (registered nurse) the staff is made aware of a stus. RN #3 stated that all of resuscitate) residents' charts red name label. In addition, in ident's clinical record, an alert paper stating that the resident this red DNR sheet is the Durable Do Not Resuscitate is asked if this information of the electronic clinical ed she did not know. At that red the electronic medical #13. She then verified that the ne Task/Kardex section esident #13 was noted to be a ked this immediately by #13's Task/Kardex to reflect atus as a DNR, after the advanced directive on the record. RN #3 stated that this generated issue" as Point the electronic medical record is so was recently updated. The system update. RN #3 ecking known DNR residents is were also inaccurate. Check, she noted several ling the residents' code status. Ild do a full check on all DNR this information is correctly	F 84				
	On 8/30/18 at 11:33 conducted with ASN	a.m., an interview was I (administrative staff rector of nursing, and ASM #4,					

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Event ID: E2S31

Facility ID: VA0177

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CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	La page a	CONSTRUCTION	FORM OMB NO (X3) DA	0: 09/14/2018 A APPROVED 0: 0938-0391 TE SURVEY MPLETED	
		405014	A. BUILDING B. WING			С	
NAME OF	PROVIDER OR SUPPLIER	495011		EET ADDRESS CITY STA		/30/2018	
		VICES-ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVI CROSS-REFERENCEI	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE DENCY)	(X5) COMPLETION DATE	
F 842	Continued From pa	age 81	F 842				
3		nce consultant. They were ost recent upgrade PCC					
	upgrade was perfo	rmed. ASM #2 and ASM #3					
		rmed on 6/4/18. ASM #2 and asked to describe the process					
		odes (without breathing and stated whoever observes a				İ	
	resident without a	heartbeat and breathlessness,					
	check the resident	e". At that time, staff will 's chart to verify the resident's					
1		and code status. Staff will this information to the staff in				1	
	the resident's room	whether the resident is a e (indicating that the resident					
	wants full resuscita	ative measure performed).					
	resident's code sta	t the process staff follows if the tus has not yet been					
		resident or the responsible ed, "We treat them as a full					
	code until we have	documentation indicating that wants to be a DNR." When		2 2			
	asked if the Task/K	ardex section of the record is					
	saving services to	inal decision to provide live a resident, ASM #2 stated,					
		not the only code status nly a "for your information"					
	documentation for	the CNAs (certified nursing asked if the code status					
	should be docume	nted accurately in all					
	and ASM #3 stated	taining to a resident, ASM #2 I, "Yes."					
	ASM (administrativ	re staff member) #1, the					
	administrator, ASM	f #2, the director of nursing, uality assurance consultant,					
	where made aware	of the above concerns on					
	8/30/18 at 11:45 a.						
	The facility staff wa	s asked to provide their policy				1 1	

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Event ID: E2S311

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

PRINTED: 09/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		TION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495011	B. WING	l		C 08/30/2018		
	PROVIDER OR SUPPLIER CARE HEALTH SERV			STREET ADDRESS, CITY, STATE, Z 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	IP CODE	1 00	100/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD	8E	(X5) COMPLETION DATE	
F 842	1) This information National Institutes of https://medlineplus 2) This information National Institutes of https://medlineplus 3) This information National Institutes of National Institutes of the National Inst	d directives. ion was provided prior to exit. was obtained from the of Health at .gov/ency/article/000299.htm was obtained from the of Health at .gov/ency/article/003185.htm was obtained from the	F	842				

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Event ID: E28311

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