STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 07/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 7/24/18 through 7/25/18. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 128 certified bed facility was 97 at the time of the survey. The survey sample consisted two current record reviews, Residents #2 and #3, and one closed record, Resident #1.	F 000	F 657 *It is the intended practice of this facility to ensure that comprehensive care plans are completed and revised as specified in 483.21(b)(2)(i)-(iii)* 1. Resident # 1 no longer resides at the facility 2. Current residents with falls from 6/23 to present will be reviewed to ensure that their care plan was updated timely post fall. Results of the audit will be reviewed by the QA committee for follow up and recommendations. 3. Current licensed nurses will be re-educated to the process of updating care plans post fall. 4. The DON/designee will audit residents with falls weekly x 4 weeks, then 2x a month for 2 months to validate that care plans were updated timely. Results of the audit will be reviewed by the QAA committee for follow up and recommendations as appropriate. 5. Facilities alleged date of compliance is 8/29/18	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mona L. Clark — TITLE: Administrator — (X6) DATE: 08/15/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to review and revise the comprehensive care plan, after a fall, for one of three residents in the survey sample, Resident #1.

The facility staff failed to update Resident #1's care plan after he suffered a fall on 6/23/18.

The findings include:

Resident #1 was admitted to the facility on 6/12/18 with diagnoses that included but were not limited to: leukemia (Leukemia is cancer of the white blood cells) (1), muscle weakness, elevated cholesterol, depression, protein - calorie malnutrition, seizures, history of a hemorrhage (bleeding) in brain, and cerebral amyloid angiopathy (Cerebral amyloid angiopathy is a condition that can cause a progressive loss of intellectual function (dementia), stroke?, and other neurological problems starting in mid-adulthood. Due to neurological decline, this condition is typically fatal in one's sixties, although there is variation depending on the severity of the signs and symptoms. Most affected individuals die within a decade after signs and symptoms first appear, although some people with the disease have survived longer). (2)

The most recent MDS (minimum data set)

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assessment, a Medicare 14 day assessment, with an assessment reference date of 6/26/18, coded the resident as usually making himself understood and the resident was coded as sometimes understanding others. The MDS coded Resident #1 as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. The resident was coded as having behaviors of inattention and disorganized thinking that comes, goes, and changes in severity. Resident #1 was coded as having verbal behavioral symptoms directed toward others and other behavioral symptoms not director toward others that occurred four to six days during the look-back period but not daily. The resident was coded as rejecting care that occurred four to six days during the look-back period but not daily. The resident was coded as requiring extensive assistance of one staff member for moving in the bed, transfers, moving on the unit, dressing, toileting and supervision of one staff member for eating. In Section J - Health Conditions, the resident was coded as having two falls without injuries.

The nurse's note dated, 6/23/18 at 8:27 p.m. documented, "Resident was in the hall sitting in w/c (wheelchair). Stood up took a few steps and lost his balance. Fell, landing on his right side and hit his head on the floor. The write (sic) and a CNA (certified nursing assistant) went to help him. Asked if he was okay and he said his head hurt. Viewed him for any injuries, no injuries noted. Assisted him back in the w/c and moments later CNA put him to bed. Began Nuro (sic) checks, took 1st set of vitals, checked his head 4 times for any bumps to his head. No bumps noted. Gave him Tylenol (used to treat pain or

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fever) (3). MD (medical doctor) and RP (responsible party) both aware."

The "Fall(s)" form dated, 6/23/18 at 8:22 p.m. documented in part, "G. Documentation: 1. Care plan initiated/revised - No."

The comprehensive care plan dated, 6/12/18, documented in part, "Focus: Fall due to weakness." The "Interventions" dated 6/12/18, documented in part, "Encourage to transfer and change positions slowly. Have commonly used articles within easy reach." The "Interventions" dated, 6/20/18 documented, "Bed in low position." The "Interventions" dated 6/22/18 documented, "Provide assist to transfer and ambulate as needed." There were no interventions added after 6/22/18.

An interview was conducted with LPN (licensed practical nurse) #1 on 7/25/18 at 2:00 p.m. When asked who updates the care plan when a resident falls, LPN #1 stated, "The nurse caring for the resident." When asked if she remembered updating the care plan, LPN #1 stated, "No, there was a lot going on."

An interview was conducted with RN (registered nurse) #1 on 7/25/18 at 2:20 p.m. When asked who updates the care plan after a resident falls, RN #1 stated, "Anyone can update the care plan but the nurse should update the care plan immediately."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 7/25/18 at 4:15 p.m. When asked if the care plan was updated for Resident #1 after his fall on 6/23/18, ASM #2 stated, "I couldn't find where we

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F 657	Continued From page 4 did that. We missed that one." The facility policy, "Interdisciplinary Care Planning" documented in part, "Evaluation: AS the care plan is implemented, members of the interdisciplinary team need to evaluate whether the interventions are effective or whether the care plan needs to be revised. Evaluating the effectiveness of care plan interventions will help the interdisciplinary team modify the care plan as needed to help the patient reach their highest practicable level of well-being." The facility policy, "Fall Practice Guide" documented in part, "The care plan is reviewed as clinically indicated to meet the patient's current needs." The administrator, ASM #2, ASM #4, the assistant director of nursing, and ASM #3, the quality assurance coordinator, were made aware of the above concern on 7/25/18 at 4:20 p.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/leukemia.html (2) This information was obtained from the following website: https://ghr.nlm.nih.gov/condition/hereditary-cerebral-amyloid-angiopathy. (3) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1622f694-4d63-4c56-8737-fae31f0ecfb7.	F 657		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842	F 842 *It is the intended practice of this facility for resident records to be complete, accurately documented, readily available and systematically organized.*	

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F 842	Continued From page 5 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842	1. Resident # 1 no longer resides at the facility. 2. Current Residents with falls from 6/23 to present will be reviewed to ensure that neurological checks are complete and filed in the medical record. Current residents who receive PRN pain medication will be reviewed to ensure that all prn medication given is documented in the MAR. Results of the audits will be reviewed by the QA committee for follow up and recommendations. 3. Current licensed nurses will be re-educated to complete and accurate medical records to include completion of neurological checks and documentation of PRN pain medication on the MAR.	

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F 842	Continued From page 6 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of three residents in the survey sample, Resident #1. 1a. The facility staff failed to document the administration of Tylenol on the medication administration record for Resident #1.	F 842	4. The DON/designee will audit residents with falls weekly x4 weeks then 2x a month for 2 months to validate that neurological check were complete and filed in the medical record. The DON/designee will audit 15 residents weekly x 4 weeks then 2 x a month for 2 months to ensure that PRN pain medication given is documented on the MAR. 5. Facilities alleged date of compliance is 8/29/18	

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F 842	Continued From page 7 1b. The facility staff failed to file neurological checks in the clinical record for Resident #1. The findings include: 1a. The facility staff failed to document the administration of Tylenol on the medication administration record for Resident #1. Resident #1 was admitted to the facility on 6/12/18 with diagnoses that included but were not limited to: leukemia (Leukemia is cancer of the white blood cells) (1), muscle weakness, elevated cholesterol, depression, protein - calorie malnutrition, seizures, history of a hemorrhage (bleeding) in brain, and cerebral amyloid angiopathy (Cerebral amyloid angiopathy is a condition that can cause a progressive loss of intellectual function (dementia), stroke?, and other neurological problems starting in mid-adulthood. Due to neurological decline, this condition is typically fatal in one's sixties, although there is variation depending on the severity of the signs and symptoms. Most affected individuals die within a decade after signs and symptoms first appear, although some people with the disease have survived longer). (2) The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 6/26/18, coded the resident as usually making himself understood and was coded as sometimes understanding others. The MDS coded Resident #1 as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. The resident was coded as having behaviors of inattention and disorganized thinking	F 842		

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that comes, goes, and changes in severity. Resident #1 was coded as having verbal behavioral symptoms directed toward others and other behavioral symptoms not director toward others that occurred four to six days during the look-back period but not daily. The resident was coded as rejecting care that occurred four to six days during the look-back period but not daily. The resident was coded as requiring extensive assistance of one staff member for moving in the bed, transfers, moving on the unit, dressing, toileting and supervision of one staff member for eating. In Section J - Health Conditions, the resident was coded as having two falls without injuries.

The nurse's note dated, 6/23/18 at 8:27 p.m. documented, "Resident was in the hall sitting in w/c (wheelchair). Stood up took a few steps and lost his balance. Fell, landing on his right side and hit his head on the floor. The write (sic) and a CNA (certified nursing assistant) went to help him. Asked if he was okay and he said his head hurt. Viewed him for any injuries, no injuries noted. Assisted him back in the w/c and moments later CNA put him to bed. Began Nuro (sic) checks (neurological checks), took 1st set of vitals, checked his head 4 times for any bumps to his head. No bumps noted. Gave him Tylenol (used to treat pain or fever) (3). MD (medical doctor) and RP (responsible party) both aware."

The physician order dated, 6/22/18, documented in part, "Tylenol (used to treat mild pain and fever) (3) 650 mg (milligrams) by mouth every 4 hours as needed for pain, not to exceed > (greater than) 3 GMs (grams) in 24 hours.

The medication administration record (MAR) for

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June 2018 documented the above order for Tylenol. The MAR failed to document the administration of the Tylenol on 6/23/18.

The "Comprehensive Care Plan" dated, 6/12/18, documented in part, "Focus: Potential for Pain." The "Interventions" documented in part, "Administer pain medication per physician orders."

An interview was conducted with LPN (licensed practical nurse) #1 on 7/25/18 at 2:00 p.m. When asked if she had given Resident #1 anything for pain on 6/23/18, LPN #1 stated she had given him some Tylenol. When asked where she documented the administration of the Tylenol, LPN #1 stated, "I would have signed it off on the MAR." When LPN #1 was informed there was no documentation on the MAR regarding the administration of Tylenol, but there was documentation in the nurse's note, LPN #1 stated, "There was a lot going on that night, I must have forgotten to sign it out."

The administrator, ASM #2, ASM #4, the assistant director of nursing, and ASM #3, the quality assurance coordinator, were made aware of the above concern on 7/25/18 at 4:20 p.m.

An interview was conducted with administrative staff member (ASM) #2 on 7/25/18 at 4:25 p.m. When asked the about the process for documentation of medication administered, ASM #2 stated, "The nurse should document immediately after giving a medication or document that it was held and write a nurse's note to explain why."

The facility policy, "Medication and Treatment

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Administration Guidelines" documented in part, "Documentation: Medications and treatments administered are documented immediately following administration or per state specific standards."

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/leukemia.html
(2) This information was obtained from the following website: https://ghr.nlm.nih.gov/condition/hereditary-cerebral-amyloid-angiopathy.
(3) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1622f694-4d63-4c56-8737-fae31f0ecfb7

1b. The facility staff failed to file neurological checks in the clinical record for Resident #1.

The nurse's note dated, 6/20/18 at 9:00 a.m. documented, "Pt (patient) heard calling out for help. I entered the room to find (Resident #1) lying on the floor with one leg still up on the bed. The call bell was in the middle of his bed. I asked (Resident #1) if (he) had any pain. He reported no pain. (Resident #1) has no obvious injuries and he had full ROM (range of motion) in all extremities with out (sic) pain. I asked (mane of physical therapist) to assess me getting (Resident #1) back to bed. V/S (vital signs - blood pressure, pulse and respirations) taken and neuro (neurological) check completed. [Charted on the flow sheet]. neuro check flow sheet initiated. (Name of Doctor) notified and is

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assessing the pt (patient) at this time. RP (responsible party) notified of pt's fall, pt's current condition, md (medical doctor) notification, assessment and intervention. Care Plan updated." Note written by RN (registered nurse) #1.

On 7/25/18 at approximately 9:00 a.m., the director of nursing was asked for the incident reports and neuro checks for the fall of 6/20/18.

An interview was conducted with RN #1 on 7/25/18 at 2:20 p.m. When asked if she initiated neuro checks on Resident #1 on 6/20/18, RN #1 stated she had started them (neurological checks) and documented them on the flow sheet. When asked where the flow sheet was located, RN #1 stated, "When we turn in our form to administration for the fall, the neuro check sheets are attached to the back of it."

The administrator, ASM #2, ASM #4, the assistant director of nursing, and ASM #3, the quality assurance coordinator, were made aware of the above concern on 7/25/18 at 4:20 p.m.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 7/25/18 at 4:25 p.m. When asked where the neuro check flow sheet was for Resident #1's fall on 6/20/18, ASM #2 stated, "I couldn't find them. I know I saw them but I cannot locate them at this time."

The facility policy, "Neurological Evaluation" documented in part, "Suggested Documentation: Completion of Neurological Evaluation Flow Sheet. Unusual observation and/or complaints and subsequent interventions including

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 07/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 12 communications with physician." No further information was provided prior to exit.	F 842		

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