DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARE

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 01/02/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	COMPLETED	
			495283	B. WING		C	
		PROVIDER OR SUPPLIER CARE HEALTH SERVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE	12/20/2018	
	(X4) ID PREFIX	SUMMARY STAT (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE	
	F 000	INITIAL COMMENT	·	F O	DEFICIENCY)	0.3.2	
		during the survey pro required for compliant Federal Long Term Compliant The census in this 12	laints were investigated ocess. Corrections are not with 42 CFR Part 483 Care requirements.				
	F 550	consisted of one cur	survey. The survey sample rent resident review, e closed record reviews, I #4.	F 55	F550 Corrective Action		
		§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			Resident #1 is wound treatment is Being administered per the physician's prescribed order and following infection control procedures Resident # 1 suffered no adverse effects and did		
	r F	with respect and dign resident in a manner promotes maintenand	y must treat each resident ity and care for each and in an environment that se or enhancement of his or ognizing each resident's		not require transfer to a higher level of care.		
	ii	ndividuality. The facil promote the rights of	ity must protect and		Corrective Action for those having the potential to be affected		
	a s n p	ccess to quality care everity of condition, c nust establish and ma ractices regarding tra	ility must provide equal regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the inder the State plan for all f payment source.	,	Residents with the treatment orders for have the potential to be affected by this alleged deficient practice. The nurse involved with the dressing change of Resident #1 was educated on the dressing change- non sterile clean policy		
- F	SOBATORY D	RECTOR'S ON PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	(X6) DATE	

(X2) MULTIPLE CONSTRUCTION

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.

16MiN: 37,4701

DEPARTMENT OF HEALTH AND HYMAN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
			A. BOILE	JING			С	
		495283	B. WING				12/20/2018	
NAME OF	PROVIDER OR SUPPLIER		J	STR	EET ADDRESS, CITY, STATE, ZIP CODE	,		
				1719	9 BELLEVUE AVENUE			
MANOR	CARE HEALTH SERV	ICES-IMPERIAL		RIC	HMOND, VA 23227			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLÉTION DATE	
F 550	Continued From pa	age 1	F 5	50	The facility will educate			
					licensed nurses on dressing chang	e		
	§483.10(b) Exercis				- non sterile clean policy.	• "	į	
		ne right to exercise his or her			The D.O.N or designee			
		of the facility and as a citizen			will observe two licensed nurses	a		
	or resident of the United States.				week x 4 weeks completing a			
	\$400 t0/h)/t). The facility must appure that the				treatment with correct dressing			
	§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without			ļ	change- non sterile clean techniqu	ıe		
	interference, coercion, discrimination, or reprisal from the facility.				After 4 weeks, two treatments a			
					month x2 months will be			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Observed by D.O.N or designee.			
	§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the				Systematic Changes			
					The D.O.N or designee			
-	exercise of his or he	er rights as required under this			will observe two licensed nurses	а		
	subpart.	With the second			week x 4 weeks completing a			
		IT is not met as evidenced		İ	treatment with correct dressing			
į	by:				change- non sterile clean techniqu	ıe		
		ion, staff interview, facility			After 4 weeks, two treatments a			
		linical record review, it was		i	month x2 months will be			
-	resident dignity duri	ity staff failed to maintain ng a dressing change for one			Observed by D.O.N or designee.			
	of four residents in t #1.	he survey sample, Resident			Monitoring			
	The facility staff was	observed writing the date the			Ongoing, compliance will be moni	tored		
		ed and initials, using a			through facility's			
	marker, directly on t Resident #1's abdon	he two dressings attached to nen.			quality assurance meeting month	ly.		
]		**************************************			We will review HCR's treatment			
-	The findings include	:			observations forms completed fo the month. Any issues	or		
F	Resident #1 was adr	mitted to the facility on			found will result in education			
9	9/27/17 with a recen	t readmission on 9/19/18,			or disciplinary action.			
1	with diagnoses that included but were not limited				action.	İ		
	o: high blood pressu							
	obstructive pulmonary disease [COPD - general term for chronic, nonreversible lung disease that				Dates Completed: 01/31/19			

	TMENT OF HEALTH	SERVICES SERVICES SERVICES			FORM	: 01/02/2019 APPROVED : 0938-0391
STATEMENT	F OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		495283	B. WING		1	C 20/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORCARE HEALTH SERVICES-IMPERIAL			1	1719 BELLEVUE AVENUE		
MANORO	JARE HEALIH SERVI	CES-IMPERIAL		RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 550	chronic bronchitis (1 impaired vision. The most recent MI assessment, an anr	ation of emphysema and 1)], depression, dementia, and DS (minimum data set) nual assessment, with an	F 550			
	assessment referent resident as scoring interview for mental resident was severe cognitive decisions. being totally dependent members for all of his Section H - Bladder coded as having an Section K - Swallow	a "3" on the BIMS (brief status) score, indicating the ely impaired to make daily. The resident was coded as dent upon one or more staffnis activities of daily living. In and Bowel, the resident was indwelling catheter. In ving/Nutritional Status, the as having a feeding tube.				
	#1 on 12/19/18 at 9: changes for Resider dressings to be come suprapubic catheter drains urine from your bladder through (2)], insertion site and tube [Gastrostomy to artificial opening into abdominal wall done insertion site. After ochanges, RN #1 app both dressings, and	ade of RN (registered nurse) :25 a.m., performing dressing int #1. The resident had two inpleted, one on the [A suprapubic catheter (tube) int bladder. It is inserted into in a small hole in your belly ind one on the gastrostomy into a surgical creation of an into the stomach through the ie to allow artificial feeding (3)], completing the dressing incompleting the dressing incomp				

Resident #1's abdomen.

then observed writing the date and her initials directly onto the tape on the dressings attached to

An interview was conducted with RN #1 on 12/19/18 at 11:17 a.m., regarding the process

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
	495283	B. WING		C 12/20/2018		
NAME OF PROVIDER OR SUPPLIER	-100200		STREET ADDRESS, CITY, STATE, ZIP COD		720/2016	
		ŀ	1719 BELLEVUE AVENUE			
MANORCARE HEALTH SERVI	ICES-IMPERIAL		RICHMOND, VA 23227			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
change. RN #1 stardate, time and initial forgot to put the time nurse is supposed to on the resident, RN with you watching managed how a nurse is to identify the unit managed how a nurse is to identify the unit managed how a nurse is to identify the period of the peri	g dressing during a dressing ted the nurse should put the als. RN #1 stated, "Oops, I e on it." When asked if a to write on a dressing while it's #1 stated, "No, I was nervous ne." Inducted on 12/19/18 with RN er, at 11:31 a.m. When asked entify when a dressing was ated, "You put the date on a put it on the dressing." When o write on the tape while the t's abdomen, RN #2 stated, Dressing Change: Non Sterile ed in part, "eld: Label tape used to a caregiver initials and ewith initials and date of secure dressing." entials for Practice, Potter and 207, pages 1015-1067, was for dating and initialing Skill 35-3 Applying Dressings: and Transparent Recording "Write your initials, date, and ange on a piece of tape in ink	F 5				

PRINTED: 01/02/2019 DEPARTMENT OF HEALTH AND HUM SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICA SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING _____ B. WING 495283 12/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1719 BELLEVUE AVENUE** MANORCARE HEALTH SERVICES-IMPERIAL RICHMOND, VA 23227 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 550 Continued From page 4 F 550 No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the following website: www.qa.nlm.nih.gov/medlineplus/275/ency/patienti nstructions/000145.htm (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. F584 F 584 Safe/Clean/Comfortable/Homelike Environment F 584 CFR(s): 483.10(i)(1)-(7) SS=D **Corrective Action** §483.10(i) Safe Environment. Resident 1 # mattress was replaced The resident has a right to a safe, clean, on 12/20/18.Resident # 1 suffered comfortable and homelike environment, including no adverse effects and did but not limited to receiving treatment and supports for daily living safely. not require transfer to a higher level of care due to tear in mattress. The facility must provide-§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to **Corrective Action for those having** use his or her personal belongings to the extent the potential to be affected. possible. (i) This includes ensuring that the resident can

and comfortable interior;

or theft.

receive care and services safely and that the

physical layout of the facility maximizes resident

the protection of the resident's property from loss

independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, An audit of the facilities mattress was

licensed nursing staff and housekeeping was educated by Maintenance on completing

20 percent mattresses will be inspected

No other mattresses were affected.

work orders for ripped mattresses.

completed on 12/28/18.

Systematic Changes

monthly for 2 months. -

	TMENT OF HEALTH	1			FORM	: 01/02/2019 APPROVED
TATEMEN"	RS FOR MEDICARE TOF DEFICIENCIES DEF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		495283	B. WING _		1	C 20/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
MANOR	CARE HEALTH SERV	ICES-IMPERIAL		1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 584	Continued From pa	ige 5	F 58	Monitoring		
	§483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);			Licensed nursing staff and house complete a work order if they ide a mattress that has a rip or tear if 20 percent mattresses will be ins	entify in it.	
	§483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature			monthly for 2 months. Ongoing, compliance will be monthly for 2 monthly	on, the month to the facility'	ily
	1990 must maintair 81°F; and §483.10(i)(7) For th	ially certified after October 1, n a temperature range of 71 to be maintenance of comfortable		Date Completed: 01/31/19		
	by: Based on observat document review, a complaint investiga facility staff failed to	NT is not met as evidenced tion, staff interview, facility and in the course of a tion, it was determined the maintain a homelike of four residents in the sident #1.				
	Resident #1 mattre rip on the top right s	ss was observed with a large side at the seam.				
•	The findings include	e:				
	Resident #1 was ac	Imitted to the facility on				No.

9/27/17 with a recent readmission on 9/19/18, with diagnoses that included but were not limited

obstructive pulmonary disease [COPD - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)], depression, dementia, and

to: high blood pressure, stroke, chronic

		AND HUN SERVICES & MEDICAN SERVICES				FORM	: 01/02/2019 APPROVED : 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
-		495283	B. WING			12/	C /20/2018	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		17	REET ADDRESS, CITY, STATE, ZIP CODI 19 BELLEVUE AVENUE CHMOND, VA 23227	E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS TAG CROSS-REFERENCED TO THE APPORTURE OF THE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS THE APPORTURE OF THE APPO			(X5) COMPLETION DATE	
F 584	Continued From pa	ge 6	F	584				
	assessment, an and assessment reference resident as scoring interview for mental resident was severe cognitive decisions, being totally dependent totally dependent totally dependent to all of high Section H - Bladder coded as having an Section K - Swallow resident was coded Observation was made of Resident #1. The right side of the mat window, was observation to the inner mattress for that was ripped was feet long and was apheight. The bed she area.	DS (minimum data set) hual assessment, with an hice date of 9/26/18, coded the a "3" on the BIMS (brief status) score, indicating the ely impaired to make daily The resident was coded as lent upon one or more staff his activities of daily living. In and Bowel, the resident was indwelling catheter. In ing/Nutritional Status, the as having a feeding tube. ade on 12/19/18 at 9:25 a.m. resident was in his bed. The tress, the side next to the red with a large rip in it, and bam was exposed. The area approximately two and a half opproximately eight inches in et was not covering the open						

unit manager.

nursing assistant) #4 on 12/19/18 at

stated the staff fills in a work order to

approximately 9:30 a.m. CNA #4 stated, "They are supposed to get him a new mattress." When asked if the ripped mattress was an infection control issue, CNA #4 stated, "Yes, I guess so." When asked about the process staff follow when something is broken or in need of repair, CNA #1

maintenance. You tell your charge nurse and the

An interview was conducted with RN (registered nurse) #1, on 12/19/18 at approximately 9:35

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

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		495283	B. WING			C 12/20/2018	
NAME OF	PROVIDER OR SUPPLIER	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	L	STREET ADDRESS, CITY, STATE, ZIP COL	<u> </u>	12/20/2010	
NAME OF	PROVIDER OR SUPPLIER				JE		
MANOR	CARE HEALTH SERVI	CES-IMPERIAL		1719 BELLEVUE AVENUE RICHMOND, VA 23227			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREI		HOULD BI		1
F 584	Continued From pa a.m. When asked if #1's ripped mattress last week." A second interview 12/19/18 at 11:17 a. saw the ripped matt towards the end of I she had done to add had called maintena mattress. An interview was comanager on 12/19/19 about the process the something broken of have to tell maintena asked if she was ma Resident #1's mattre been made aware a of environmental se in the mattress was RN #2 stated, "Yes, would be more of ar of the mattress." An interview was comember) #1, the en- on 12/19/18 at 11:51		F 5	CROSS-REFERENCED TO THE AP DEFICIENCY) 84	PROPRIA		
	made aware of Resi OSM #1 stated, "I wanted days ago. We have asked how long they mattresses, OSM #1 about a month." OSI mattress from an em	When asked if she was dent #1's ripped mattress, as told about it a couple of mattresses on order." When have been waiting for the stated, "I believe it has been with #1, was asked why a appty bed had not been taken, or full OSM #1 stated. "What					

CENT	<u>ERS FOR MEDICARI</u>	<u> & MEDIL</u> <u>D SERVICES</u>			<u> </u>	<u> DMR MC</u>). 0938-0391	
STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495283	B. WING			12/20/2018		
NAME O	F PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MANO	RCARE HEALTH SERV	ICES-IMPERIAL			719 BELLEVUE AVENUE ICHMOND, VA 23227			
(X4) ID PREFIX TAG			ID PREFI TAG		ON D BE PRIATE	(X5) COMPLETION DATE		
F 584	I will do is go pull or replace it." OSM #1 informed the writer changed out and the The facility policy, "I documented in part includes the bed fra patient and immedia surrounding the bed may differ in sleeping of a safe bed environted in the surrounding the bed in the surrounding the bed may differ in sleeping of a safe bed environted in the surrounding the bed environted in the surrounding the bed environted in the surrounding the surroundi	returned at 12:05 p.m. and that the mattress had been rown away." Bed Environment", "The bed environment me, the support surface, ate geographic environment frame. While individuals ag and sleep habits, creation nment that takes into account	F	684				
	movement is based evaluation by the int physician, patient ar equipment is inspectand upgraded on a second control of the cont	nd familyThe bed system ted, evaluated, maintained outine basis and as needed."		· · · · · · · · · · · · · · · · · · ·				
	administrator, ASM ASM #3, the assista made aware of the a 12:08 p.m. When as concerned with the r there were two reasons.	member (ASM) #1, the #2, the director of nursing and nt director of nursing, were above concern on 12/19/18 at ked why this writer was nattress, ASM #1 stated ons, one was the comfortable nt and the other is infection						
	No further informatio	n was provided prior to exit.						
	Non-Medical Reader Chapman, page 124.	Comprehensive Care Plan	F 65	66				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 01/02/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDI OMB NO. 0938-0391 D SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495283 B. WING 12/20/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1719 BELLEVUE AVENUE** MANORCARE HEALTH SERVICES-IMPERIAL RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 656 Continued From page 9 F 656 F656 §483.21(b) Comprehensive Care Plans Corrective Action: Resident #1's §483.21(b)(1) The facility must develop and Oxygen is being administered at implement a comprehensive person-centered prescribed rate Resident #2 has been care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and discharged from the facility §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's Potential residents to be affected. medical, nursing, and mental and psychosocial Other residents receiving Oxygen has needs that are identified in the comprehensive the potential can be affected. assessment. The comprehensive care plan must Other residents with order for psych describe the following consults have the potential to be affected. (i) The services that are to be furnished to attain or maintain the resident's highest practicable **Systematic Changes:** physical, mental, and psychosocial well-being as An audit of all POC was completed for required under §483.24, §483.25 or §483.40; and residents with order for Oxygen (ii) Any services that would otherwise be required License Nurses will be re-educated under §483.24, §483.25 or §483.40 but are not to administer resident's oxygen at the provided due to the resident's exercise of rights prescribed rate. An audit of all POC was under §483.10, including the right to refuse treatment under §483.10(c)(6). completed for residents with order for (iii) Any specialized services or specialized psych service IDT will be re-educated rehabilitative services the nursing facility will by the DON/Designee on the importance provide as a result of PASARR of implementing a comprehensive recommendations. If a facility disagrees with the care plan by obtaining psych consults as findings of the PASARR, it must indicate its ordered. rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-

desired outcomes.

entities, for this purpose.

(A) The resident's goals for admission and

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the

PRINTED: 01/02/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDI&) SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ C 495283 B. WING 12/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE MANORCARE HEALTH SERVICES-IMPERIAL RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) Continued From page 10 F 656 requirements set forth in paragraph (c) of this **Monitoring System:** section. This REQUIREMENT is not met as evidenced DON/designee will complete random audit bv: of 5 residents receiving oxygen for Based on observation, staff interview, facility compliance with prescribed rate document review, clinical record review and in the Social Services director/designee course of a complaint investigation, it was will complete a random audit of 5 residents determined the facility staff failed to implement care plan for implementation of comprehensive the care plan for two of four residents in the care plan for psychiatrist consults survey sample, Residents #1 and #2. Audit will be completed weekly for 4 weeks and monthly for 2 months. 1. The facility staff failed to implement Resident Identified discrepancies will be addressed #1's comprehensive care plan for the accordingly, and as appropriate. administration oxygen. Such will be forwarded to the QA&A committee for further review and/or possible revisions to facility The facility staff failed to implement Resident # protocol 2's comprehensive care plan for obtaining a psychiatry consult. The Facility alleges complains on 1/31/19 The findings include: 1. Resident #1 was admitted to the facility on 9/27/17 with a recent readmission on 9/19/18, with diagnoses that included but were not limited to: high blood pressure, stroke, chronic obstructive pulmonary disease [COPD - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. (1)], depression, dementia, and impaired vision.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 9/26/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as being totally dependent upon one or more staff

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

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FORM.	APPROVED
OMB NO.	0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L' IDENTIFICATION MINUSED.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495283	B. WING			C 12/20/2018			
	PROVIDER OR SUPPLIER		· .	STREET ADDRESS, CITY, STATE, 1719 BELLEVUE AVENUE RICHMOND, VA 23227	ZIP CODE		20,2010		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE		
	members for all of Section H - Bladder coded as having an Section K - Swallow resident was coded. The comprehensive documented in part oxygen therapy r/t (exchange and nebull "Interventions" documented by physical and effectiveness." Observation was made 12/18/18 at 2:37 p.m. with oxygen on via a stratt insert into the number concentrator. The owas set at 3L/min (list observation was made 12/19/18 at 8:41 a.m. the resident, and the observed at 3L/min. made of the resident masal cannula concentrator. The owas set at 3L/min. On 12/19/18 at 9:50 at 31/min. On 12/19/18 at 9:50 at 31/min. The physician order of C2 (oxygen) @ (at)	his activities of daily living. In and Bowel, the resident was a indwelling catheter. In wing/Nutritional Status, the as having a feeding tube. It care plan dated, 6/22/18, "Focus: The resident has related to) ineffective gas dizer treatment." The amented, "Give medications cian. Monitor for side effects and of Resident #1 on the resident was observed a nasal cannula (two prongs ose) connected to an oxygen exygen-concentrator flow rate ters per minute). A second de of Resident #1 on the nate of Resident #1 on the nate of Resident #1 on the oxygen was in use by the flow rate setting was a third observation was to on 12/19/18 at 9:25 a.m. the his oxygen was in use via onnected to an oxygen exygen-concentrator flow rate of the oxygen was in use via onnected to an oxygen exygen-concentrator flow rate a.m., RN (registered nurse) erve Resident #1's oxygen this writer the flow rate of the oxygen was set at dated, 9/19/18, documented, 2 liters per minute via nasal elated to Chronic Obstructive	F 6	956					

	TMENT OF HEALTH	AND HUN SERVICES & MEDICAN SERVICES				FORM APPROVED B NO. 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING _	·		C 12/20/2018	
NAME OF	PROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, Z	ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-IMPERIAL		1719 BELLEVUE AVENUE RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD B		
F 656	Continued From pa Pulmonary Disease	-	F 65	56			
	12/19/18 at 11:17 a. of the comprehension for the care of the pensure they get the if the staff should for stated, "Yes." When Resident #1's compwas care planned to physician order, and set at the incorrect remanager, on 12/19/10 the purpose of the comprehension of the comprehensio	anducted with RN #1 on m. When asked the purpose we care plan, RN #1 stated it's atient and their safety to care they need." When asked llow the care plan, RN #1 asked if staff were following rehensive care plan if oxygen to be administered per the if Resident #1's oxygen was rate, RN #1 stated, "No." Inducted with RN #2, the unit 18 at 11:31 a.m. When asked comprehensive care plan, RN ideline of patient care for the					
	staff to follow. Wher followed, RN #2 state followed, RN #2 state The facility policy, "In Planning" document Once the care plan is implement the intervolan. These may incomministering treatm performing therapies with the patient." According to Fundar Williams and Wilking documented, "A writt communication tool members that helps careThe nursing careThe nursing care	n asked if it should be ted, "Yes." Interdisciplinary Care ted in part, "Implementation: is developed, the staff must ventions identified in the care flude, but is not limited to: nents and medications, is and participating in activities mentals of Nursing Lippincott is 2007 pages 65-77 ten care plan serves as a among health care team					

and goals. It contains detailed instructions for achieving the goals established for the patient

DEPARTMENT OF HEALTH AND HUN SERVICES

PRINTED: 01/02/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495283	B. WING			1	C /20/2018
	PROVIDER OR SUPPLIER	CES-IMPERIAL		1719 BE	ADDRESS, CITY, STATE, ZIP CODE LLEVUE AVENUE DND, VA 23227	1	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI ROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 656	and is used to direct revise and update to there are changes in with new orders" Administrative staff administrator, ASM ASM #3, the assistate made aware of the 12:08 p.m. No further information. Hon-Medical Reader Chapman, page 12-2. The facility staff for 2's comprehensive apsychiatry consult. Resident #2 was ad 2/23/18 with diagnostimited to: anxiety di Parkinson's disease neurological disordet tremor, shuffling gai motions of the finge weakness, sometime (1)], seizures, high be disorder, and trauments"	the care mexpect to review, the care plan regularly, when an condition, treatments, and the member (ASM) #1, the #2, the director of nursing and ant director of nursing, were above concern on 12/19/18 at the member of the er, 5th edition, Rothenberg and 4. The plan for obtaining a mitted to the facility on ses that included but were not sorder, depression, er, [a slowly progressive er characterized by resting tr, stooped posture, rolling re, drooling and muscle es with emotional instability. Blood pressure, mood attic brain injury [TBI - mp, blow, jolt, or other head	F6	56	JENOLINO!)		
	assessment, a quar assessment referen the resident as scori	DS (minimum data set) terly assessment, with an ce date of 10/17/18, coded ing a "12" on the BIMS (brief status) score indicating the					The state of the s

	TMENT OF HEALTH	AND HUN SERVICES			· O	FORM): 01/02/2019 1 APPROVEE): 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	COM	TE SURVEY MPLETED
		495283	B. WING			í	C /20/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-IMPERIAL			719 BELLEVUE AVENUE ICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 656	cognitive decisions. being capable of mas usually understa was not coded as hof delirium. In Sectivas not coded as hosychosis or having during the past sever period. Resident #2 supervision of one shed, transferring from surface, dressing, to the resident require staff member for was independent in moveating. The comprehensive documented in part, symptom r/t (related depression and anxional dated 8/8/18 documental status/behaving medication started of Psych (psychiatry) resident as usually resident part, symptom started of the part	rately impaired to make daily Resident #2 was coded as aking himself understood, and nding others. The resident aving any signs or symptoms on E - Behaviors, the resident aving any indicators of any behavioral symptoms en days of the look back was coded as requiring staff member for moving in the om one surface to another colleting and personal hygiene. ed limited assistance of one alking in the corridor, and was ing on and off the unit and e care plan dated, 8/8/18, "Focus: At risk for behavior	F6	:56			

call his sister or soda."

During an interview with LPN (licensed practical nurse) #3 on 12/19/18 at 9:57 a.m., LPN #3 stated Resident #2 was involved in a

resident-to-resident incident on 8/8/18. Another resident entered his room and sat on the bed. Resident #2 went out into the hallway and started screaming, "Get this damn man out of my room."

The facility staff stated that it took some encouragement to get the resident out of

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

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	COV	PLETED
		495283	B. WING	i		i	/20/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
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	don't get out of my there and fuck him The clinical record of saw Resident #2 on the psychiatrist adjumedication. The Budisorders. (3)] was if (milligrams) one tabe day. The resident we [used to treat anxiet 60 mg by mouth ever the psychiatrist adjumedications. The Budisorders and the psychiatrist adjumedications. The Budisorders and the psychiatrist adjumedications. The Budisorders and the psychiatrist adjumedications. The Budisorders and the psychiatrist adjumedications and the psychiatrist adjumedications. The Budisorders and the psychiatrist adjumedications and the psychiatrist adjumedications. The Budisorders and the psychiatrist adjumedications and the psychiatrist adjumedication and the psychiatri	Resident #2 stated, "If he room, I am gonna come in up." documented, the psychiatrist in 5/5/18. Per documentation, asted Resident #2's spar [used to treat anxiety increased to 15 MG olet by mouth three times a last to remain on Cymbalta by and generalized anxiety. (4)] ary day. documented, the psychiatrist in 6/16/18. Per documentation, asted Resident #2's uspar was continued, arted on Zoloft [is used to treat in the twon't go away and ings, irritability, bloating, and (5)] 50 mg one tablet by used to the documented, the psychiatrist in 7/14/18. He adjusted cation. The Buspar was coloft was increased to 100 mg	Fe	356			
An angles plant of the format	yelling/repetitive ver inappropriate disrup			WHEE			

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAD SERVICES

House		
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONST	RUCTION	(X3)	COMPLETED
		495283	B. WING				C 12/20/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		1719 BELI	DDRESS, CITY, STATE, ZIP CO LEVUE AVENUE ND, VA 23227)DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORI EACH CORRECTIVE ACTION S OSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Resident #2, dated "Identified Behaviora aggression, agitatio Patient immediate the Additional comment near resident room. being verbally aggreher to get the **** or (responsible party) or continue therapy an get out the place." The "Behavioral Syr Resident #2, dated "Identified Behaviora aggression. Patient no." Additional Commenter resident and inappropriate names. The "Behavioral Syn Resident #2, dated "Identified Behavioral Syn Resident #2, dated "Identified Behaviora aggression, socially immediate threat to a "Identified Behavioral Syn Resident #2, dated 1" Identified Behavioral Syn Resident #	others - no." mptom Assessment" for 8/13/18, documented in part, al Symptoms - verbal n, irritability or hyperactivity. In reat to others - yes. It is: was standing in the hall resident could be heard essive towards his sister. Told at (use profanity). Revenue to the was saying he wanted to the was saying he wanted to the mptom Assessment" for 10/8/18, documented in part, al Symptoms - verbal immediate threat to others - ments: Resident in his with the hall way, when he saw the began to call the resident in part, al Symptoms - verbal disruptive behaviors. Patient others - no."	F 6	56			

DEPARTMENT	OF HEALTH	AND HU	SERVICES
CENTERS FOR	R MEDICARE	& MEDICATO	SERVICES

PRINTED:	01/02/2019
FORM A	APPROVED
OMB NO.	0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST A. BUILDING				E SURVEY IPLETED			
		495283	B. WING			1	C 20/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERV	I,		1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227		20/2010
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F 656	failed to evidence a or visits. An interview was constaff member (ASM) on 12/19/18 at 8:04 psychiatrist did not ASM #2 stated the ended. When asked psychiatric services stated the facility is out to two different for treatment. When not sent out for constant of the incident with ASM #2 stated she contract for psychiatric services administrator, stated facility as the administrator, stated facility as the administrator, stated facility as the administrator, stated facility as the administrator of the psychiatric services his comprehensive an intervention, to help the stated, "No, Ma'a ASM #1, the adminition of nursing, and ASM nursing, were made on 12/19/18 at 12:28.	onducted with administrative (1) #2, the director of nursing, a.m. When asked why the see Resident #2 after 7/14/18, contract with that psychiatrist d how residents in need of being taken care of, ASM #2 currently sending the resident hospitals and one psychiatrist in asked why Resident #2 was tinued psychiatric services th another resident on 8/8/18, didn't know. A copy of the tric services was requested to of the expiration of the (18 at 12:22 p.m., ASM #2 yor that the contract could not ame time, ASM #1, the did that when he arrived at the distrator, he has been trying to ices in the building. They be psychiatric services in When asked if not having for Resident #2 was following care plan that documents, as ave psychiatry services, ASM am, it's not."	F 6	656			

		AND HUMAN SERVICES		forman,		MAPPROVED
CENT	ERS FOR MEDICARE	& MED(D SERVICES			OMB NO	D. 0938-0391
STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION NG		TE SURVEY
		495283	B. WING _		12	C 2/20/2018
NAME O	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MANO	RCARE HEALTH SERVI	CES-IMPERIAL		1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 656	Non-Medical Reader Chapman, page 437 (2) This information following website: https://medlineplus.eq (3) This information following website: https://vsearch.nlm.imeta?v%3Aproject=medlineplus-bundled 601.934922596.154 1256 (4) This information following website: https://vsearch.nlm.rmeta?v%3Aproject=medlineplus-bundled 045508.934922596.8851256 (5) This information following website: https://vsearch.nlm.rmeta?v%3Aproject=medlineplus-bundled 01.934922596.15453	r, 5th edition, Rothenberg and	F 65	56		
F 695 SS=D	256 Respiratory/Tracheos CFR(s): 483.25(i)	stomy Care and Suctioning	F 695	F695 Corrective Action.		
	The facility must ensured respiratory car care and tracheal succare, consistent with practice, the compret	nd tracheal suctioning. ure that a resident who e, including tracheostomy etioning, is provided such professional standards of nensive person-centered ats' goals and preferences,		Resident #1's oxygen is being Administered per the physician's prescribed rate. Resident # 1 suffered no adverse effects and o not require transfer to a higher lo	lid	

PRINTED: 01/02/2019

PRINTED: 01/02/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDI D SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 495283 12/20/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1719 BELLEVUE AVENUE MANORCARE HEALTH SERVICES-IMPERIAL RICHMOND, VA 23227 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 19 F 695 Potential residents to be affected. This REQUIREMENT is not met as evidenced Residents with the order for Based on observation, staff interview, facility Oxygen have the potential to be document review, clinical record review, and in affected by this alleged deficient the course of a complaint investigation, it was practice. The facility will audit determined the facility staff failed to administer residents with oxygen orders to oxygen at the physician prescribed rate for one of ensure that the correct number of four residents in the survey sample, Resident #1. liters are at the physicians prescribed rate via eagle room. The facility staff failed to administer Resident #1's oxygen at the physician prescribed rate of two **Systematic Changes** liters per minute. licensed nursing staff will be re-educated The findings include: on administering oxygen at physician prescribed rate Resident #1 was admitted to the facility on 9/27/17 with a recent readmission on 9/19/18, with diagnoses that included but were not limited Monitoring to: high blood pressure, stroke, chronic obstructive pulmonary disease [COPD - general DON/designee will conduct random audits term for chronic, nonreversible lung disease that of 5 residents on oxygen is usually a combination of emphysema and weekly for 4 weeks and then monthly for chronic bronchitis. (1)], depression, dementia, two months to ensure liters are set to and impaired vision. physician's prescribed rate. The most recent MDS (minimum data set) assessment, an annual assessment, with an Identified discrepancies will be addressed assessment reference date of 9/26/18, coded the accordingly, and as appropriate will be resident as scoring a "3" on the BIMS (brief

interview for mental status) score, indicating the

cognitive decisions. The resident was coded as being totally dependent upon one or more staff members for all of his activities of daily living. In

Section H - Bladder and Bowel, the resident was coded as having an indwelling catheter. In Section K - Swallowing/Nutritional Status, the resident was coded as having a feeding tube.

resident was severely impaired to make daily

forwarded to the QA&A committee

for further review and/or possible

The facility alleges complain on 1/31/19

revisions to facility protocol.

DEPAR	I MENT OF HEALTH	AND HUL SERVICES			FORM	MAPPROVED
CENTE	RS FOR MEDICARE	& MEDIC SERVICES			OMB NO	D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		TE SURVEY
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NAME OF	PROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		· · · · · · · · · · · · · · · · · · ·
			-	1719 BELLEVUE AVENUE		
MANOR	CARE HEALTH SERVI	CES-IMPERIAL	1	RICHMOND, VA 23227	- '	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 695	Continued From pa	ge 20	F 695			
	12/18/18 at 2:37 p.m with oxygen on via a that insert into the n concentrator. The owas set at 3L/min (li observation was ma 12/19/18 at 8:41 a.m the resident, and the observed at 3L/min. made of the resident resident was awake the nasal cannula concentrator. The owas set at 3L/min. On 12/19/18 at 9:50 #1 was asked to observed and tel	ade of Resident #1 on m. the resident was observed a nasal cannula (two prongs nose) connected to an oxygen oxygen-concentrator flow rate iters per minute). A second ade of Resident #1 on m. The oxygen was in use by the flow rate setting was at third observation was at on 12/19/18 at 9:25 a.m. the set, his oxygen was in use via onnected to an oxygen onnected to an oxygen onnected to an oxygen of a.m., RN (registered nurse) serve Resident #1's oxygen lithis writer the flow rate of the oxygen was set at				
Peppi dissili	"O2 (oxygen) @ (at)	dated, 9/19/18, documented, 2 liters per minute via nasal related to Chronic Obstructive				The second secon
	documented in part, oxygen therapy r/t (r exchange and nebul "Interventions" docu	care plan dated, 6/22/18, "Focus: The resident has related to) ineffective gas lizer treatment." The mented, "Give medications cian. Monitor for side effects				

On 12/19/18 at 9:50 a.m., RN (registered nurse) #1 was asked to observe Resident #1's oxygen concentrator and tell this writer the flow rate

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DEPARTMENT OF HEALTH AND I	3	SERVICES
CENTERS FOR MEDICARE & ME	DICATO	SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		E CONSTRUCTION .		E SURVEY MPLETED	
		495283	B. WING			1	C /20/2018
	PROVIDER OR SUPPLIER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE ICHMOND, VA 23227	1 12	20,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	setting. RN #1 state 3L/min. An interview was con 12/19/18 at 11:17 and rate Resident #1's of #1 stated she believed asked to read Resident he oxygen. When a following the physic the oxygen. When a following the physic the process staff following the process staff following ordered oxygen to be stated, "They should When asked how of the setting of the oxygen was tated. The above ob #2. RN #2 stated she had turned the oxygen was tated she had adjusted the oxygen was tated to part, the facility policy, "Odocumented in part,"	and the oxygen was set at an and the oxygen was to be set on, RN and the oxygen was to be set on, RN and the staff were stan order, RN #1 stated, "No." and the staff were stan order, RN #1 stated, "No." and the staff were stan order, RN #1 stated, "No." and the staff were stan order, RN #1 stated, "No." and the staff were stan order, RN #1 stated, "No." and the staff were stan order, RN #2, the unit staff when the physician has set at 2L/min. RN #2 at the oxygen at two liters." At the nurse should check the staff was shared with RN and gone into the room on the set at three liters. RN #2 and it down to the prescribed stated that someone must k up to three between the and the staff when this	F6	895	DEFICIENCY)		
	According to Fundar Potter, 6th edition, p treated as a drug. It such as atelectasis	rator, plug in power cord, turn meter to correct flow rate." mentals of Nursing, Perry and age 1122, Oxygen should be has dangerous side effects, or oxygen toxicity. As with		restration (restriction to the state of the			

PRINTED: 01/02/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDI D SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ C R WING 495283 12/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE MANORCARE HEALTH SERVICES-IMPERIAL RICHMOND, VA 23227 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 695 Continued From page 22 F 695 should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on 12/19/18 at 12:08 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. F 740 Behavioral Health Services F 740 CFR(s): 483.40 SS=D F740 §483.40 Behavioral health services. Each resident must receive and the facility must **Corrective Action** provide the necessary behavioral health care and services to attain or maintain the highest Resident #2 has been discharged from the facility. practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive Potential residents to be affected assessment and plan of care. Behavioral health Residents with order for Psychiatric consult encompasses a resident's whole emotional and has the potential to be affected mental well-being, which includes, but is not limited to, the prevention and treatment of mental An audit of residents with orders for psychiatric and substance use disorders.

This REQUIREMENT is not met as evidenced

Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide psychiatric services services have been completed

		I AND HUMAN SERVICES		March of the state	FORM); 01/02/201 1APPROVE
	ERS FOR MEDICARE		<u> </u>			. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG		TE SURVEY MPLETED
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		495283	B. WING _			/20/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
MANOR	CARE HEALTH SERVI	CES-IMPERIAL		1719 BELLEVUE AVENUE		
				RICHMOND, VA 23227		
(X4) ID PREFIX TAG	, (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 740	Continued From page	ne 23	F 74			
, , , ,		ents in the survey sample,		·		
	Resident #2.	,,,,,,,,,,,,,,,,,,,,	ļ			ĺ
			:	Systematic Changes:	÷	
	The facility staff fails services for Resider	ed to provide psychiatric			norconnol	
	1	altercation on 8/8/18.	į į	icensed nursing and social services Will be re-educated on the appropr	iste nrocess	
	rootaon to rootaon			for the follow up with order.	rate process	
	The findings include	:		io die ionom up mini e uo.		
	Decident #2 was ad	mittad to the facility on		Monitoring System:		
		mitted to the facility on ses that included but were not				
	limited to: anxiety dis		Į.	Director of social services/designee	will complete	for
		, [a slowly progressive		a random audit of 10 resident's ph psychiatric consults and that arran		101
		r characterized by resting		psychiatric consults and that arrain completed for resident to be seen	bv a psychiatr	ist.
		s, stooped posture, rolling s, drooling and muscle		Audit will be completed weekly for		
		es with emotional instability.		and monthly for 2 months.		
		lood pressure, mood				
-	disorder, and trauma			dentified discrepancies will be add	ressed	
	happens when a bur injury causes damag	np, blow, jolt, or other head e to the brain. (2)].		accordingly, and as appropriate.		
ĺ	-			Results of audit be forwarded to th	e QA&A	
		S (minimum data set)		Committee for further review and/	or possible	
		erly assessment, with an ee date of 10/17/18, coded		revisions to		
		ng a "12" on the BIMS (brief		facility protocol.		
		status) score indicating the				
-	resident was modera	tely impaired to make daily	(Completion date: 01/31/19		
		Resident #2 was coded as			1	
		king himself understood, and ding others. The resident			,	
		ving others. The resident				
4		g any organo or opinipionile		į –	1	

of delirium. In Section E - Behaviors, the resident

was not coded as having any indicators of psychosis or having any behavioral symptoms during the past seven days of the look back period. Resident #2 was coded as requiring supervision of one staff member for moving in the bed, transferring from one surface to another

	MENT OF HEALTH	AND HU SERVICES			FORM	7: 01/02/2019 MAPPROVED). 0938-0391
STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495283	B. WING			C /20/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP 1719 BELLEVUE AVENUE RICHMOND, VA 23227	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	The resident require staff member for was independent in move eating. The clinical record of saw Resident #2 on the psychiatrist adjumedication. The Bust disorders. (3)] was is (milligrams) one tab day. The resident was [used to treat anxiet 60 mg by mouth ever the clinical record of saw Resident #2 on the psychiatrist adjumedications. The Bust Resident #2 was stated pression, obsessis [bothersome though including mood swind breast tenderness] (mouth every morning the clinical record of saw Resident #2 on Resident #2's medications.	polleting and personal hygiene. The limited assistance of one alking in the corridor, and was ring on and off the unit and documented, the psychiatrist in 5/5/18. Per documentation, usted Resident #2's spar [used to treat anxiety increased to 15 MG off let by mouth three times a last to remain on Cymbalta by and generalized anxiety. (4)] ery day. Idocumented, the psychiatrist 6/16/18. Per documentation, sted Resident #2's uspar was continued, and on Zoloft [is used to treat in the two-compulsive disorder its that won't go away and and so, irritability, bloating, and so)] 50 mg one tablet by go. Idocumented, the psychiatrist 7/14/18. He adjusted in the Buspar was bloft was increased to 100 mg	. F740			
Administration and applying a second and a second a second and a second a second and a second a	nurse) #3 on 12/19/1 stated Resident #2 v	with LPN (licensed practical 18 at 9:57 a.m., LPN #3 vas involved in a incident on 8/8/18. Another				

resident entered his room and sat on the bed. Resident #2 went out into the hallway and started PRINTED: 01/02/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		L' INCATEDATION AUMOED.		X2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING			Į.	C / 20/2018	
	PROVIDER OR SUPPLIER			171	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE CHMOND, VA 23227		Euro-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL I LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 740	screaming, "Get the The facility staff state encouragement to Resident #2's room don't get out of my there and fuck him. The comprehensive documented in part symptom r/t (related depression and an dated 8/8/18 documedication per phy mental status/behamedication started Psych (psychiatry) patient when he be call his sister or so	his damn man out of my room." tated that it took some o get the resident out of m. Resident #2 stated, "If he y room, I am gonna come in n up." ve care plan dated, 8/8/18, art, "Focus: At risk for behavior ed to) mood disorder, exity." The "Interventions" emented in part, "Administer envior changes when new d or with changes in dosage. ecomes agitated by offering to oda."	F 7	740				
	Resident #2, dated "Identified Behavio aggression, agitatic resistance to ADLs yelling/repetitive ve inappropriate disruidemands, unsafe in immediate threat to The "Behavioral Sy Resident #2, dated "Identified Behavioral ggression, agitatic Patient immediate Additional commen near resident room being verbally aggrest to get the **** of the state of the s	dymptom Assessment" for d, 8/8/18, documented in part, oral Symptoms - verbal ion, irritability or hyperactivity, is (activities of daily living), erbalizations, socially uptive behaviors, unrealistic impulsive behaviors. Patient is o others - no." ymptom Assessment" for d 8/13/18, documented in part, oral Symptoms - verbal ion, irritability or hyperactivity. Ithreat to others - yes. ints: was standing in the hall in. Resident could be heard ressive towards his sister. Told out (use profanity). RP						

	MENT OF HEALTH	AND HUN SERVICES & MEDICAN SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCȚION	(X3) DAT	E SURVEY MPLETED
		495283	B. WING				C 20/2018
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 740	get out the place." The "Behavioral Syr Resident #2, dated "Identified Behaviora aggression. Patient no." Additional Comwheelchair going do another resident and inappropriate names. The "Behavioral Syr Resident #2, dated "Identified Behaviora aggression, socially immediate threat to The "Behavioral Syr Resident #2, dated "Identified Behaviora aggression. Patient no. Additional Common.	mptom Assessment" for 10/8/18, documented in part, al Symptoms - verbal immediate threat to others - ments: Resident in his own the hall way, when he saw d began to call the resident s." mptom Assessment" for 10/29/18, documented in part, al Symptoms - verbal disruptive behaviors. Patient	F	740			
	Further review of Re	esident #2's clinical record ny further psychiatric consults					
	staff member (ASM) on 12/19/18 at 8:04 psychiatrist did not s ASM #2 stated the c ended. When asked psychiatric services	nducted with administrative #2, the director of nursing, a.m. When asked why the ee Resident #2 after 7/14/18, ontract with that psychiatrist how residents in need of being taken care of, ASM #2 currently sending the resident		The second secon			

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

PRINTED:	01/02/2019
FORM	APPROVED
OMB NO.	0938-0391

		IDENTIFICATION MUMBED.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495283 B. WING		ľ	С				
		<u>. I </u>	D. WING			12/	20/2018	
NAME OF I	PROVIDER OR SUPPLIER	l			REET ADDRESS, CITY, STATE, ZIP CODE			
MANORO	CARE HEALTH SERV	/ICES.IMPERIAL		17	19 BELLEVUE AVENUE			
WANON	JANE HEALIN OLIN	NOES-IMI EINAE		RI	CHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 740	out to two different for treatment. Whe not sent out for co after the incident w	age 27 thospitals and one psychiatrist en asked why Resident #2 was ntinued psychiatric services with another resident on 8/8/18, et didn't know. A copy of the	F7	740				
	contract for psychicheck on the date contract. On 12/19 informed this surve be located. At this administrator, state facility as the administrator service currently do not ha house at this time. psychiatric services his comprehensive an intervention, to #2 stated, "No, Maintervention on the date of the service and the service at the service and the	atric services was requested to of the expiration of the 9/18 at 12:22 p.m., ASM #2 eyor that the contract could not same time, ASM #1, the ed that when he arrived at the nistrator, he has been trying to vices in the building. They ve psychiatric services in When asked if not having a for Resident #2 was following a care plan that documents, as have psychiatry services, ASM cam, it's not."						
	of nursing, and ASI nursing, were mad on 12/19/18 at 12:2 No further informat (1) Barron's Diction Non-Medical Read Chapman, page 43 (2) This information following website: https://medlineplus (3) This information following website: https://vsearch.nlmmeta?v%3Aproject	ion was provided prior to exit. nary of Medical Terms for the er, 5th edition, Rothenberg and						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAD SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 01/02/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			C		
	•	495283		i			12/20/2018	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
			J	1	1719 BELLEVUE AVENUE			
MANOR	CARE HEALTH SERVI	CES-IMPERIAL]	F	RICHMOND, VA 23227			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	BE	(X5) COMPLETION	
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE	
			<u> </u>		DEI IOIENOT,		<u> </u>	
F 740	Continued From pa	aae 28	F 7	740				
* • • •	1256	3			•			
		was obtained from the				I		
•	following website:					i		
	https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query- meta?v%3Aproject=medlineplus&v%3Asources=				· ·	١		
Ī						I		
ļ	medlineplus-bundle	&query=Cymbalta&_ga=2.264				1		
	1	.1545340204-938173006.146				ļ		
	8851256	was obtained from the			Tarent in the second se	ļ		
	(5) This information following website:	was obtained not the				ļ		
		.nih.gov/vivisimo/cgi-bin/query-				ļ		
	meta?v%3Aproject=	=medlineplus&v%3Asources=						
	medlineplus-bundle	medlineplus-bundle&query=Zoloft&_ga=2.338186				ļ		
	01.934922596.1545340204-938173006.1468851				F880			
	256	1		יחח	Corrective Action:			
F 880	Infection Prevention		F8		Resident #1 Nurse was immediately			
SS=D	CFR(s): 483.80(a)(1	,)(2)(4)(e)(ī)	ļ		re-educated on completing dressing			
	§483.80 Infection Co	ontrol	changes using proper infection control practices.					
	9403.00 miccion of The facility must est	tablish and maintain an	İ		Upon notification by the surveyor, reside	ent #1		
	infection prevention	and control program			mattress was immediately replaced.			
	designed to provide	a safe, sanitary and	İ		and the same			
5	comfortable environ	ment and to help prevent the	1		Potential residents to be affected.			
	development and tra	ansmission of communicable	l		- durantum changoe he			
97 V. A.	diseases and infection	ons.	1		Residents receiving dressing changes ha	ive		
		and control	į		the potential to be affected. All resident's mattress has the potential	i to		
		prevention and control	ł		be affected.	110		
Ì	program. The facility must est:	ablish an infection prevention	l		be affected.			
	and control program	(IPCP) that must include, at	i		Systematic Changes:			
	a minimum, the follo	owing elements:	(License Nurses will be re-educated to co	mplete		
			i		dressing change using proper infection of			
	§483.80(a)(1) A syst	tem for preventing, identifying,	!		practicesLicensed nursing staff will be			
	reporting, investigation	ing, and controlling infections	ı		re-educated on completing wound			
	and communicable of	diseases for all residents,			care using proper infection control technique	nique		
	staff, volunteers, visi	itors, and other individuals			1		l	
	providing services un	upon the facility assessment		- !				
i	arrancemen oascu	BUUT HIE RECHIL AGGEOGINE		,				

(X2) MULTIPLE CONSTRUCTION

DEPARTMENT OF HEALTH AND HI IN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	01/02/2019
FORM.	APPROVED
OMB NO.	0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING			l	C
NAME OF	פאסעייטרים סיים פעומטיינים	493203	10. 11.110		STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	/20/2018
NAME OF	PROVIDER OR SUPPLIER		ļ		1719 BELLEVUE AVENUE		
MANOR	CARE HEALTH SERVI	CES-IMPERIAL			RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(2.10.100)			(X5) COMPLETION DATE
	conducted accordinaccepted national si §483.80(a)(2) Writte procedures for the pout are not limited to (i) A system of surve possible communication infections before the persons in the facilit (ii) When and to who communicable disease reported; (iii) Standard and trato be followed to pre (iv) When and how is resident; including by (A) The type and dur depending upon the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstances must prohibit employ disease or infected scontact with residents contact will transmit to (vi) The hand hygiene by staff involved in disease or infected scontact will transmit to (vi) The hand hygiene by staff involved in disease or infected scorrective actions taked (483.80(e) Linens. Personnel must hand	g to §483.70(e) and following tandards; en standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other y; om possible incidents of ase or infections should be used for a cut not limited to: ration of the isolation, infectious agent or organism at the isolation should be the ible for the resident under the es under which the facility rees with a communicable kin lesions from direct so or their food, if direct he disease; and procedures to be followed rect resident contact.	F 8	880	An audit of all mattress has be comple Admin/Designee will re-educate mair Director to complete bed/mattress at a year per facility policy and all staff immediately complete a work order notifying the Maintenance Director owith any mattress. Monitoring System: DON/designee will conduct random at of 2 license nurses weekly for 4 week then monthly for two months to ensure that wound care is being cousing proper infection control technical Admin/Designees will complete rand audit of 10 resident mattresses assess weekly for 4 weeks and monthly for Identified discrepancies will be address accordingly, and as appropriate at Q for further review and/or possible reprotocol. The facility alleges complain on 1/31,	ntenance udit twice to request f any issent audits audits audits cs and ompleted que om sing for 2 montlessed A&A core evisions	ee ues d rips hs.

	TMENT OF HEALTH	AND HUN SERVICES & MEDICAND SERVICES				FORM	: 01/02/2019 I APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION .	COM	E SURVEY MPLETED
	•	495283	B. WING	ì		1	/20/2018
NAME OF F	PROVIDER OR SUPPLIER			l	STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	CES-IMPERIAL		ŀ	1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 30	H	880)		
	IPCP and update the This REQUIREMENT by: Based on observation document review, of the course of a composition determined the facility faction control practices during a different to the facility staff faction of the facility staff faction of the facility staff faction of the facility staff faction of the facility staff faction of the facility staff faction of the facility staff faction of the facility staff faction of the facility staff faction of the facility staff faction of the facility staff factions of the factions of the fac	luct an annual review of its eir program, as necessary. IT is not met as evidenced ion, staff interview, facility linical record review, and in plaint investigation, it was ity staff failed to follow ctices for one of four vey sample, Resident #1. ailed to follow infection control ressing change for Resident ailed to maintain infection the maintenance of Resident Resident #1 mattress was the rip on the top right side at					
		: ailed to follow infection control g a dressing change for					
	9/27/17 with a recen with diagnoses that i to: high blood presso obstructive pulmona term for chronic, nor	mitted to the facility on t readmission on 9/19/18, included but were not limited ure, stroke, chronic ry disease [COPD - general nreversible lung disease that tion of emphysema and					

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

	PRINTED: 01/02/2019
}	FORM APPROVED
	OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING			1	C (00/0010	
NAMEOE	PROVIDER OR SUPPLIER	730200	1		ET ADDRESS, CITY, STATE, ZIP CODE	121	/20/2018	
NAME OF	PHOVIDER ON SUFFLIER				BELLEVUE AVENUE			
MANOR	CARE HEALTH SERVI	CES-IMPERIAL			MOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPERTY)	BE	(X5) COMPLETION DATE	
F 880	Continued From parchronic bronchitis (impaired vision. The most recent MI assessment, an annuassessment referent resident as scoring interview for mental resident was severe cognitive decisions. being totally dependent members for all of his Section H - Bladder coded as having an Section K - Swallow resident was coded Observation was made of RN (registered nudressing changes to catheter [A tube that bladder. It is inserted		F 8	80		MAIE		
	tube [a surgical creatinto the stomach three to allow artificial feet gloves and proceed from the resident's splaced the removed RN #1 then proceed from Resident #1's gremoved dressing in them to discarded the removed gloves dressing on the night to contain a package sponges in their package sponges on the center of the removed gloves dressing on the removed gloves dressing on the night to contain a package sponges in their package sponges on the center of the removed gloves.	ation of an artificial opening ough the abdominal wall done oling. (3)]. RN #1 put on her ed to remove the dressing suprapubic catheter. She dressing on the nightstand. ed to remove the dressing pastrostomy tube and put the her glove as she removed be gloves. RN #1 then placed containing the gatrostomy tstand, which was observed e of four by four drain kages. The dirty dressing orner of the clean package.						

	TMENT OF HEALTH	HAND HUN SERVICES E & MEDICARD SERVICES					MAPPROVED 0. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495283	B. WING	à		12	C 2/ 20/2018
NAME OF I	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	ICES-IMPERIAL		1	1719 BELLEVUE AVENUE RICHMOND, VA 23227		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	catheter insertion sidrain sponges obset the resident's suprainsertions site. RN is and proceeded to coff the gastrostomy tube. An interview was considered at 12/19/18 at 11:17 and dressing should be part of the dressing clean drain sponge, asked if a nurse is the different dressing sishould change glow was shared with RN. An interview was comanager, on 12/19/asked where the direction performing a dressing "You discard it in the two dressings are bechange their gloves dressing sites, RN is done individually." The facility policy, "I (Clean)" documented Place waste receptationside, under the own soiled dressing and Remove soiled glove hygiene.	site and then placed one of the erved on the nightstand around apubic catheter at the #1 did not change her gloves clean around the insertion site tube. She then placed a ge around the insertion site of oe. Onducted with RN #1 on a.m. When asked if a dirty placed on the nightstand with a touching the package of the RN #1 stated, "No." When to change gloves between two ites, RN #1 stated, "Yes, we wes." The above observation N #1. Onducted with RN #2, the unit with at 11:31 a.m. RN #2 was rry dressing be placed when ing change. RN #2 stated, the trash can." When asked if the between the two different with the stated, "Yes, it should be accepted in part, "Procedure: 7. The accepted in part, "Procedure: 7. The accepted in trash bag26. The accepted in tra	F	880			
	administrator, ASM	#2, the director of nursing and					

DEPARTMENT OF HEALTH AND HUN

PRINTED: 01/02/2019

DEPARTMENT OF HEALTH AND HU 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	
			A. DUILL	ЛИС			С	
		495283	B. WING	i		12/	20/2018	
NAME OF	PROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE			
MANOR	CARE HEALTH SERV	/ICES-IMPERIAL		1	1719 BELLEVUE AVENUE			
**************************************	W/11 (11 12 12 12 12 12 12 12 12 12 12 12 12 1			<u> </u>	RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880		-	F 8	880			were both described to the control of the control o	
		tant director of nursing, were e above concern on 12/19/18 at					Adding a control of the control of t	
	No further informat	tion was provided prior to exit.	l					
	Non-Medical Read Chapman, page 12 (2) This information following website: wwwqa.nlm.nih.gov nstructions/000145 (3) Barron's Dictio Non-Medical Read Chapman, page 24	n was obtained from the v/medlineplus/275/ency/patienti 5.htm nary of Medical Terms for the ler, 5th edition, Rothenberg and 13. failed to maintain infection						
VILLANGERALE / PREMIUM AND AND AND AND AND AND AND AND AND AND		or the maintenance of a ess for Resident #1.						
	9/27/17 with a rece with diagnoses that to: high blood press obstructive pulmon term for chronic, no is usually a combin	dmitted to the facility on ent readmission on 9/19/18, tincluded but were not limited sure, stroke, chronic lary disease [COPD - general correversible lung disease that lation of emphysema and [1)], depression, dementia, and						
	assessment, an an assessment referer resident as scoring interview for mental resident was severe cognitive decisions.	DS (minimum data set) nual assessment, with an nce date of 9/26/18, coded the a "3" on the BIMS (brief I status) score, indicating the ely impaired to make daily . The resident was coded as						

	TMENT OF HEALTH	%					APPROVED . 0938-0391
STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) ML	JLTIP	PLE CONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUIL	DING	3		APLETED C
		495283	B. WING				/20/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>	
MANOR	CARE HEALTH SERVI	ICES-IMPERIAL	·	1	1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	members for all of I Section H - Bladder coded as having an Section K - Swallow resident was coded Observation was m of Resident #1. The right side of the marwindow, was observation in the inner mattress of that was ripped was feet long and was a height. The bed she area. An interview was conursing assistant) # approximately 9:30 are supposed to get asked if the ripped recontrol issue, CNA when asked about something is broker stated the staff fills maintenance. You to unit manager. An interview was conurse) #1, on 12/19, a.m. When asked if mattress, RN #1 staff saw the ripped matt towards the end of I	his activities of daily living. In and Bowel, the resident was a indwelling catheter. In wing/Nutritional Status, the das having a feeding tube. Inade on 12/19/18 at 9:25 a.m. the resident was in his bed. The attress, the side next to the resident was exposed. The area is approximately two and a half approximately eight inches in the et was not covering the open conducted with CNA (certified 44 on 12/19/18 at a.m. CNA #4 stated, "They et him a new mattress." When mattress was an infection #4 stated, "Yes, I guess so." The process staff follow when an or in need of repair, CNA #1		880			
	maintenance to get	him a new mattress.				ŀ	

DEPARTMENT OF HEALTH AND HUN

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DEPARTMENT OF HEALTH AND HU 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	
		495283	B. WING			1	C /20/2018
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-IMPERIAL				171	REET ADDRESS, CITY, STATE, ZIP CODE 9 BELLEVUE AVENUE CHMOND, VA 23227		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		BE .	(X5) COMPLETION DATE
F 880	An interview was of manager on 12/19, what the staff does broken or ripped, Finaintenance or hoshe was made away mattress, RN #2 staware and had told environmental servithe mattress was a RN #2 stated, "Yes would be more of a of the mattress." An interview was comember) #1, the eleon 12/19/18 at 11:5 mattress is ripped with the mattress is ripped with the was made away mattress, OSM #1 couple of days ago order." When asked waiting for the mattress been take waiting for the mattress been take #1 stated, "What I wanother room and red 12:05 p.m. and info	age 35 conducted with RN #2, the unit /18 at 11:31 a.m. When asked s when they find something RN #2 stated, "We have to tell ousekeeping." When asked if are of the rip in Resident #1's tated she had been made d (name of director of vices). When asked if the rip in an infection control concern, s, but the rip is on the edge. It an issue if it was in the middle conducted with OSM (other staff nvironmental service director, 51 a.m. When asked if a what is to be done with it, OSM d be replaced." When asked if are of Resident #1's ripped stated, "I was told about it a b. We have mattresses on d how long have they been tresses, OSM #1 stated, "I about a month." When stated e facility is not full, why hasn't a en from an empty bed? OSM will do is go pull one from replace it." OSM #1 returned at ormed the writer that the changed out and thrown	F8	80			
	away." Administrative staff administrator, ASM ASM #3, the assistamade aware of the	member (ASM) #1, the I #2, the director of nursing and ant director of nursing, were above concern on 12/19/18 at sked why this writer was					

	TMENT OF HEALTH	AND HUN SERVICES & MEDICAID SERVICES				FORM	: 01/02/2019 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
	·	495283	B. WING	ì		1	C 20/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-IMPERIAL		l	1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	there were two reas homelike environme control. The facility policy, "I documented in partincludes the bed frapatient and immedia surrounding the bed may differ in sleepir of a safe bed enviropatient's medical nemovement is based evaluation by the interphysician, patient are equipment is inspectant upgraded on a second control of the	mattress, ASM #1 stated cons, one was the comfortable ent and the other is infection Bed Environment" "The bed environment me, the support surface, ate geographic environment of frame. While individuals ag and sleep habits, creation nament that takes into account eds, comfort and freedom of on individualized patient	F	880			

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