PRINTED: 07/30/2019 **FORM APPROVED** OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING			1	C
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 0//	18/2019
14,4,5				ļ	719 BELLEVUE AVENUE		
MANOR	CARE HEALTH SERV	ICES-IMPERIAL			RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 000	E 000 Initial Comments		F	000	F-554		8-29-19
F 000	An unannounced E survey was conduct 07/18/2019. The fall compliance with 42 Requirement for Lo INITIAL COMMENT An unannounced M survey was conduct 07/18/2019. Correct	ng-Term Care Facilities. S dedicare/Medicaid standard sed 07/16/2019 through stions are required for	FC		The statements made on this plant correction are not an admission to a do not constitute an agreement with the alleged deficiencies cited herein. remain in compliance with all feder and state regulations, the center ha taken or will take the actions set forth the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected i the date or dates indicated. It is the intended practice of this facil	nd pin To al is in in in	
F 554 SS=D	Term Care requirem survey/report will fol investigated during. The census in this 1 98 at the time of the consisted of 54 resident Self-Admir CFR(s): 483.10(c)(7) \$483.10(c)(7) The rimedications if the in	28 certified bed facility was survey. The survey sample dent reviews. Meds-Clinically Approp ght to self-administer terdisciplinary team, as	F 5	54	to ensure the residents right to self- administer medications if the interdisciplinary team, as defined by 483.21(b)(2)(ii), has determined tha this practice is clinically appropriate 1. Resident #7 was educated on 7-1 19 regarding self-administration of medication. 2. No other residents reside in the facility who self-administer medications. 3. Director of Nursing and/or Designee to educate nursing staff	7- of	
	this practice is clinic This REQUIREMEN by: Based on observati interview, facility door record review, it was failed to complete a assessment for one sample to keep med Resident #7. The facility staff faile assessment for Resi	on, resident interview, staff cument review and clinical determined the facility staff self-administration of 54 residents in the survey lications at their bedside,	ATURE		on policy/procedure for self- administering medication. 4. Director of Nursing and/or designee to audit resident charts with a BIMs of 12 or higher for self administering medication daily x 5 days, then three days a week x 3 weeks and then monthly x 2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendation will be discussed and implemented as needed. 5. The facility's alleged date of compliance will be August 29, 2019	5	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495283	B. WING _		, j	C 0 7/18/2019
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	SIMPERIAL	•	STREET ADDRESS, CITY, STATE, ZIP CO 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 554	her room. The finding include: Resident #7 was add 10/11/18 with diagnorm of limited to: multiple disease in which ner spinal cord lose their disorder, morbid obe depression. The most recent MD assessment, a quart assessment reference resident as scoring a interview for mental resident was capable decisions. On 7/16/19 at 2:32 professional forms and the second revealed to the further observation of Melatonin* 10 mg (me 60 tablets. The bottlessions)	mitted to the facility on uses that included but were esclerosis [a progressive ve fibers of the brain and myelin cover. (1)], anxiety sity, diabetes, and S (minimum data set) erly assessment, with an edute of 4/18/19, coded the "15" on the BIMS (brief status) score, indicating the e of making daily cognitive o.m., observation Resident me resident was in the room.	F 5	54		8-29-19
	Resident #7 at this til why she had the bott bedside table. Reside because the ones the don't always work, he your mouth and work asked where she got Resident #7 stated si (name of an on-line s asked if the facility kr	wwas conducted with me. Resident #7 was asked le of medication on her ent #7 stated she used it at the facility is giving her er personal ones dissolve in better. Resident #7 was the bottle of Melatonin. he had ordered them off shopping company). When hew she had this in her room, They've been there for quite				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		#		•		С	
		495283	B. WING			07	/18/2019
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-IMPERIAL		1	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 554	They sit on my table a the facility completed questions, to determine keep this bottle of Me Resident #7 stated, "It Observation was mad 7/17/19 at approximate bottle remained on the *Melatonin is a hormore brain called the pinear regulate your sleep cy it's time to go to sleep up. (2) The physician's order "Melatonin 10 mg by round and July 2019, ophysician's order. The documented as administration of the comprehensive called the facility of the physician's order. The documented as administration of the comprehensive called the facility of the physician's order. The documented as administration of the comprehensive called the facility of the physician's order. The comprehensive called the facility of the physician's order. The comprehensive called the facility of the physician's order.	at all times." When asked if an assessment, asking her he if it was safe for her to latonin at her bedside, No." The of Resident #7's room on tely 9:30 a.m. The Melatonin e bedside table. The made by a part of the ligiand. Melatonin helps yield. It tells your body when and when it's time to wake the dated 6/7/19, documented, mouth at bedtime." The administration record) for documented the above of medication was aistered each night.	F	554			8-29-19
	effects related to: use "Interventions" documentations) on MAR Review of the clinical adocumentation that as self-administration of relations.	record failed to evidence sessment for					
	nurse) #2, on 7/17/19	lucted with RN (registered at 3:05 p.m. When asked if edications in their room, RN ust be kept in the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	430200	1 0. 10 -	STREET ADDRESS, CITY, STATE, ZIP CO.		<u>07/18/2019</u>	
	ARE HEALTH SERVICES	-IMPERIAL		1719 BELLEVUE AVENUE RICHMOND, VA 23227	5 2		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 554	medication cart." An interview was con- 7/17/19 at 3:22 p.m. Vicep medications at to "No Ma'am." When as she found medication #3 stated, "I would as identify the medication supervisors." LPN #3 bottle in Resident #7's An interview was condinterim unit manager, When asked if a resident the bedside, RN #6 need a doctor's order resident. An assessmit would need to be compared a lock box."	ducted with LPN #3 on When asked if residents can he bedside, LPN #3 stated, sked what she would do if s in a resident's room, LPN k the resident what it was, n and report it to my was shown the Melatonin s room. ducted with RN #6, the on 7/17/19 at 3:30 p.m. ent can have medications s stated, "No. We would	F 5	54		8-29-19	
	staff member (ASM) # director of nursing, on asked if a resident car room, ASM #2 stated, unless they have a se assessment complete	2, the administrative 7/17/19 at 4:19 p.m. When have medications in their "They are not supposed to If-administration d to determine if they are					
	Self-Administration of in part, "The patient has self-administer medicateam (IDT) has determated inically appropriate, self-administration is apatient, the IDT should	edication Administration: Medications" documented as the right to ations if the interdisciplinary nined that this practice is					

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[495283	B. WING		· · · · · · · · · · · · · · · · · · ·	1) /18/2019
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	ARE HEALTH SERVICES	IMPERIAL		171	9 BELLEVUE AVENUE		
MARCINO	AIL HEALIN SERVICES			RIC	CHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)		(X5) COMPLETION DATE
F 554	Continued From page	4	F	554			8-29-19
	medications(s) for sel						1
		acity to swallow without					
		medication bottles. The		1			
		tus, included their ability to					1 1
i		nedications and know what					
	conditions the are take						1
		ctions and tell time to know		i i			1 1
		to be taken. The patient's					
		tructions for the medications					1 1
	they are taking, includ	ing the dose, timing, and					
	signs of side effects, a	and when to report to facility					
	staff. The patient's ab	ility to understand what					
	refusal of medication i	s, and appropriate steps					
		ate when this occurs. The	1				1
	•	ure that medication is stored					
-	safely and securely. T						
	•	ter medication(s) is subject					1
		nt by the IDT based on					
	changes in the patient			i			!
		sAfter the completion of					
	the evaluation, the pat		İ				
	results of the evaluation						
I	declares their intent to						
	medications administe			i			
		edications. The resident minister of medication after					
1	the evaluation has bee		1	\dashv			
		itient is granted approval to					
		edications. The patient	1				
		with the individual who					
		on process to the patient.					
	•						
j	Administrative staff me	ember (ASM) #1, the					
		the administrative director				;	İ
1		3, the quality assurance				,	
	consultant, were made						
	concerns on 7/18/19 a						
	No further information	was obtained prior to exit.					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING			Į.	C
NAME OF D	ROVIDER OR SUPPLIER	430203	0. 7		TREET ADDRESS, CITY, STATE, ZIP CODE	07	/18/2019
NAME OF P	ROVIDER OR SUPPLIER		ĺ				
MANORC	ARE HEALTH SERVICES				719 BELLEVUE AVENUE RICHMOND, VA 23227		
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F 554	Continued From page	5	F	554			8-29-19
F 558 SS=D	Non-Medical Reader, Chapman, page 380 (2) This information work following website: https://familydoctor.org. Reasonable Accommon CFR(s): 483.10(e)(3) The right services in the facility accommodation of respreferences except when danger the health of other residents. This REQUIREMENT by:	g/melatonin/?adfree=true odations Needs/Preferences at to reside and receive with reasonable ident needs and	F	558	F – 558 The statements made on this plan of correction are not an admission to an do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies	d n o in	8-29-19
	interview, facility docur record review, it was d failed to ensure accom- needs for two of 54 res	ment review, and clinical letermined the facility staff imodation of resident sidents in the survey			cited have been or will be corrected by the date or dates indicated. It is the intended practice of this facilit to provide residents the right to reside	y	
	94 55	0, and #61. The facility ue call bell was in reach for ident #61.			and receive services in the facility with reasonable accommodation of residen needs and preferences except when to	t	133
:	The findings include:				do so would endanger the health or safety of the resident or other residents.		
	9/27/17 with a recent re diagnoses that include stroke, dementia, high	dmitted to the facility on eadmission on 4/26/19 with d but were not limited to: blood pressure, and atrial characterized by rapid and the atria of the heart			10 L 4		

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		495283	B. WING				07/18/2019
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MANODO	4 DE 115 4 LTU DEDIGOS	MADEDIAL		17			
MANORC	ARE HEALTH SERVICES	SAMPERIAL		RI	ICHMOND, VA 23227		
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							8-29-19
F 558	Continued From page	e 6	F	558	1. On 7-16-19 starr		1
	causing irregular bea	ts of the ventricles and			took immediate		1
	resulting in decrease	d heart output and frequently			correction of call		
	clot formation in the a	atria (1)].	1		bell in reach for		[
					resident # 40 & #	61	
	The most recent MDS	-			2. Residents who		1
	assessment, a quarte	erly assessment, with an			reside in facility		
		e date of 6/4/19, coded the			have the potentia	ıf	i
		"3" on the BIMS (brief			to be affected.		
		tatus) score, indicating the			3. Nurses re-		
i		impaired to make daily			educated on call		
	, •	he resident was coded as		- 1	light policy.		
	_ •	nt upon one or more staff			4. Director of Nursi	ng	
	members for all of the	eir activities of daily living.		ŀ	and/or designee		
					will complete		
	Observation was mad			- 1	random audits	_	
		o.m. of Resident #40 in his			ensuring call bell	S	
-		circular pancake style, call			are within reach daily x 5 days, the	an.	
i		ll bell designed for residents			three days a wee		
		ing a regular style call bell)		i	3 weeks and the		
	was observed on the				monthly x 2	•	
ĺ		This was again observed			months. Resu	ts of	
i	on 7/16/19 at 3:32 p.n	n.		- 1	the QAA audit	s will	
	D				be reviewed b	y the	1
İ		hensive care plan revised			facility's QAA		
		vidence documentation for	1		Committee.		
	the use of a call bell		 	\dashv	Recommenda		
	An intension was seen	husted with LDN /lineared			will be discuss		
		ducted with LPN (licensed 7/17/19 at 3:35 p.m. When			and implemen	ited	
		could use the call bell, LPN			as needed.		
	#5 stated, "Yes, when	•			5. The facility's		
	no stateu, 165, WIEII	RS WILLIE TEACH.			alleged date o		
	The facility policy "Ca	Il Light" documented in			compliance w		
		n call light conveniently for			August 29, 20	4.J.	1
	use and within reach."						
	ASM #1, the administr	rator, ASM #2, the					
		of nursing, and ASM #3,	1	Į			
	the quality assurance	consultant were made	1	ĺ			1

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING				C /18/2019
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-IMPERIAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 558	aware of the above cop.m. No further information (1) Barron's Dictionary Non-Medical Reader, Chapman, page 55. 2. The facility staff fail was in reach for Resident Resident #61 was adr 9/14/16, with diagnose	was obtained prior to exit. y of Medical Terms for the 5th edition, Rothenberg and led to ensure the call beli lent #61. nitted to the facility on es that included but were hrenia [Any of a group of	F	5558			8-29-19
	distortions of reality, we language, perception (1)], and macular degeneration, or agedegeneration (AMD), it loss in Americans 60 and destroys your sharp, or	vithdrawal of thought, and emotional response. eneration (Macular related macular is a leading cause of vision and older. A disease entral vision. You need bjects clearly and to do					
	assessment reference resident as having bot memory difficulties. The requiring supervision this activities of daily living Observation was made 7/16/19 at 12:02 p.m. asleep. The call bell w	ly assessment, with an date of 6/19/19, coded the h short and long-term he resident was coded as o extensive assistance with ving.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		E CONSTRUCTION		ATE SURVEY DMPLETED	
		495283	B. WING			C 07/18/2019	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 558	p.m.		F 558			8-29-19	
		nade on 7/17/19 at 9:24 a.m. bed with the call bell inside nightstand.					
		ehensive care plan dated, lence documentation of the					
	nurse) # 5 on 7/17/19	ducted with RN (registered at 2:39 p.m. When asked if the call bell, RN #5 stated,		12			
	nursing assistant) # 5 When asked where concern when asked if they slated, "Within When asked if they slated, "No." When be placed in a resider #5 stated, "No." When	ducted with CNA (certified on 7/17/19 at 3:20 p.m. all bells should be placed, in reach of the resident." hould be on the floor, CNA in asked the call bell should int's nightstand drawer, CNA in asked if Resident #61 can #5 stated, "He's blind but it be within reach."	:				
	the quality assurance	rator, ASM #2, the r of nursing, and ASM #3, consultant were made oncerns on 7/17/19 at 4:50					
	(1) Barron's Dictionary	was obtained prior to exit. of Medical Terms for the 5th edition, Rothenberg and as obtained from the					

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NILIMPED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
			A. BOILDIN			С	
		495283	B. WING_			07/18/2019	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	···	011,10,2010	
MANORO	ADE UEALTU CERMORO	MIDEDIAL		1719 BELLEVUE AVENUE			
MANURU	ARE HEALTH SERVICES	-IMPERIAL		RICHMOND, VA 23227			
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F 558	Continued From page	9	F 5	58		8-29-19	
	https://vsearch.nlm.ni	h.gov/vivisimo/cgi-bin/query- nedlineplus&v%3Asources=					
		query=age-related+macular				8 20 10	
F 578 SS=E	Request/Refuse/Dscn	tnue Trmnt;FormIte Adv Dir	F 5	78 F-578		8-29-19	
	§483.10(c)(6) The right discontinue treatment to participate in experi formulate an advance §483.10(c)(8) Nothing construed as the right the provision of medic services deemed med inappropriate. §483.10(g)(12) The far requirements specified subpart I (Advance Dir (i) These requirements inform and provide write residents concerning to medical or surgical treatments.	int to request, refuse, and/or to participate in or refuse imental research, and to directive. in this paragraph should be of the resident to receive all treatment or medical lically unnecessary or cility must comply with the d in 42 CFR part 489, rectives). is include provisions to the right to accept or refuse		The statements made on this correction are not an admission do not constitute an agreement the alleged deficiencies cited heremain in compliance with all and state regulations, the certaken or will take the actions so the following plan of correconstitutes the center's alleged compliance. All alleged deficiencited have been or will be correthed at or dates indicated it is the intended practice of the to comply with the requirer specified in 42 CFR part 489, so (Advance Directives) 1. Upon notifications are not considered in 18-19 the	on to and not within nerein. To I federal noter has eet forth in action ation of iencies eeted by eed is facility ments ubpart I		
	(ii) This includes a writter facility's policies to impand applicable State la (iii) Facilities are permientities to furnish this in legally responsible for requirements of this se (iv) If an adult individuation of admission and information or articulate has executed an advantage and information or articulate the second information or articul	ten description of the blement advance directives aw. Itted to contract with other information but are still ensuring that the action are met. al is incapacitated at the		administrat departmen educated or advance dir by the Administrat 2. Residents v reside at the	t was re- n ectives or.		

STATEMENT OF DEFICIENCIES = (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 578	with State Law. (v) The facility is not reprovide this information or she is able to receive follow-up procedures the information to the appropriate time. This REQUIREMENT by: Based on staff intervireview, and clinical redetermined that the facility and provide information directive and/or provide advance directives for the survey sample, Re55#, #45, #79, #248, and the findings include: 1. The facility staff fair on developing an advato Resident #36 or R	relieved of its obligation to on to the individual once he ive such information. Is must be in place to provide individual directly at the is not met as evidenced lew, facility document ecord review, it was acility staff failed to inform ion to develop an advance de periodic reviews of the releven of 54 residents in residents #36, #24, #26, .70, #39, #64 and #40.	F	578	have the portone to be affect. 3. Social Service Department Admissions department educated on advance director and designee will randomly autoresident charand/or new adaily x 5 days three days as 3 weeks and monthly x 2 months. Resulthe QAA audit be reviewed by facility's QAA Committee. Recommenda	ed. ices t and re- n ectives or. and es /or I dit rts admits i, then week x then ilts of ts will oy the	8-29-19
	05/18/19 with diagnos not limited to heart fail disorder (2). Resident (minimum data set), at with an ARD (assessm 05/25/19, coded Resident the brief interview for a score of 0 - 15, eight impaired of cognition for the state of the second s	# 36's most recent MDS n admission assessment nent reference date) of dent # 36 as scoring a eight or mental status (BIMS) of			will be discuss and implemen as needed. 5. The facility's alleged date or compliance wi August 29, 201	f Il be	

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		495283	B. WING			1	C /18/2019
	NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-IMPERIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	record) for Resident # Services Assessment 05/18/2019. Under "A documented, "2. Does decision maker report has been completed? planning has been cod (durable power of atto the patient/patient's do information on advance Further review of the of failed to evidence a cod durable power of attor On 7/17/19 at 1:31 p.r. conducted with OSM (OSM #4 (the social wo resident has advance will or power of attorne the admission coordin obtaining a copy of the scanning the copy into On 7/18/19 at 8:49 a.n. conducted with OSM #	and History" dated advance Care Planning" it is that advance care planning Yes. 3. What advance care impleted? a) DPOA-HC impleted? a) DPOA-HC impleted? b) DPOA-HC impleted? a) DPOA-HC impleted? a) DPOA-HC impleted? b)	F	570	8		8-29-19
	advance directives in pshe is supposed to obdirectives, scan the dosystem and place a cochart. On 07/17/19 at 3:20 p. conducted with OSM (other staff member) # 3,					
	don't have an advance information but if they	r, regarding advance (ated, "If they (residents) directive we don't offer the ask for it we provide it." ecifically conduct periodic					

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		1	A. BOILD	ING			С	
		495283	B. WING			07	/18/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	,	71012010	
				-	1719 BELLEVUE AVENUE			
MANORC.	ARE HEALTH SERVICES	HMPERIAL			RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 578	Continued From page	e 12	F	578			8-29-19	
	reviews of resident's a	advance directives to	İ					
	determine if they wan	t to change anything or if the						
		ation to develop an advance						
		m., ASM (administrative						
		administrator, confirmed						
	, ·	Ivance directives were not						
	representatives.	residents and/or their						
		m., ASM #1 confirmed the						
		copy of Resident # 36's						
		hen asked if a copy of						
	advance directives sh	•						
	resident's clinical reco "Absolutely."	ord, ASM #1 stated,						
	The facility's policy "A							
	Planning/Advance Direction	actives inservice Advance Care Planning?						
ľ	Advance care planning							
i		pals, values, and choices					F 1	
	concerning future heal	•			1		ļ i	
ļ	_	and health care provides					į l	
		g a shared understanding	-					
	of the patient's future of							
		ussion topics include the					i i	
ĺ		ining treatments), who						
		ealth care proxy, and other					 	
	personal, emotional ar						j	
		g is not about death, but is						
		t one's lifetime. Advance						
		not be confused with an					! 1	
	advance directive. The						[
		of documents, but rather the ts and families in important						
		ication. Advance Directive.	1					
	An advance directive is							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRU NG		(X3) DATE SURVEY COMPLETED C		
•		495283	B. WING			٥	7/18/2019
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-IMPERIAL		1719 BELLE	ORESS, CITY, STATE, ZIP CODE EVUE AVENUE D, VA 23227	'	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 578	It is made in advance to make his or her ow directives: it states a preatment. It may also treatment choices if the advance directive help accept or refuse medical capabilities, he or she care decisions. The advance directives the factifficult medical care of behalf. There are basedirectives: 1. a living with medical treatment the 2. a durable power of indicates who has been decisions about medical treatment directives: 1. The condition of the	riences a debilitating illness. , while the patient is still able in decisions. It gives catient's choices about on ame someone to make ne patient cannot. An os ensure the desire to cal treatment is carried out. It has decision-making continues to make health advance directive is used is lost. Advance directives amily of having to make decisions on the patient's sicially two types of advance will indicates what type of patient wants in the future. attorney for health care en selected to make cal treatment if the patient is climately 5:00 p.m., ASM ember) #1, the M #2, the administrative	F	578			8-29-19
-	above findings. No further information References: (1) A condition in whice to pump oxygen-rich be efficiently. This causes throughout the body. obtained from the web	was provided prior to exit. th the heart is no longer able clood to the rest of the body is symptoms to occur. This information was					
	(2) Fear. This informa	tion was obtained from the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495283	B. WING			C 07/18/2019		
	NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-IMPERIAL			1	STREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	REET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	tD PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 578	website: https://www.nlm.nih.g #summary.	e 14 gov/medlineplus/anxiety.html ailed to evidence information	F	578		y	8-29-19	
:	on developing an ad- to Resident # 24 or F representative.	vance directive was provided Resident # 24's		j				
	03/14/19 with diagno not limited to cerebra mellitus (2). Resident (minimum data set), a assessment with an A date) of 05/06/19, co- scoring a nine on the status (BIMS) of a sc	ARD (assessment reference						
	record) for Resident # Services Assessment	d the EHR (electronic health \$ 24 revealed a "Social and History" dated Advance Care Planning" it						
	documented, "2. Doe decision maker report has been completed? planning has been co (durable power of attothe patient/patient's d information on advanter review of the failed to evidence a codurable power of attothe complete the codurable power of attothe complete the codurable at 1:31 p.1	s the patient/patient's t that advance care planning Yes. 3. What advance care mpleted? a) DPOA-HC princy-health care). 5. Does ecision maker want be care planning? Yes." clinical record and the EHR ppy of Resident # 24's mey for health care.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AN MADED.) MULTIPLE CONSTRUCTION BUILDING			SURVEY PLETED
		495283	B. WING				C /18/2019
ļ	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-IMPERIAL	•	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	OSM #4 (the social w resident has advance will or power of attorn the admission coordin obtaining a copy of th scanning the copy into On 7/18/19 at 8:49 a. conducted with OSM coordinator). OSM #2 advance directives in she is supposed to obdirectives, scan the dosystem and place a cochart. On 07/17/19 at 3:20 p conducted with OSM (social services directodirectives. OSM # 3 state of the company	orkers). OSM #3 stated if a directives (such as a living ey) upon admission, then hator is responsible for e advance directives and to the computer system. m., an interview was #2 (the admission a copy of the advance occuments into the computer opy of the documents in the occuments into the computer opy of the documents in the occuments into the computer opy of the documents in the occuments i	F	578			8-29-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495283 NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-IMPERIAL		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495283	B, WING_		C 07/18/2019		
			STREET ADDRESS, CITY, STATE, ZIP (1719 BELLEVUE AVENUE RICHMOND, VA 23227				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 578	"Absolutely." On 07/18/19 at appro (administrative staff n administrator, and AS director of nursing, we above findings. No further information References: (1) A stroke. When bibrain stops. A stroke attack." If blood flow few seconds, the brain oxygen. Brain cells cadamage. This informat website: https://medlineplus.go. (2) A chronic disease regulate the amount of information was obtain	eximately 5:00 p.m., ASM member) #1, the sM #2, the administrative ere made aware of the ere made aware of the ere made aware of the ere made aware of the ere made aware of the ere made aware of the ere made aware of the ere made aware of the ere made aware of the ere made aware of the ere sometimes called a "brain is cut off for longer than a ere cannot get nutrients and ere causing lasting ere ere ere ere ere ere ere ere ere er	F	578		8-24-19	
	reviews were conduct 26's advance directive Resident # 26 was ad 04/25/11 with diagnos not limited to dysphag Resident # 26's most is set), a quarterly asses (assessment reference Resident # 26 as scorinterview for mental st	mitted to the facility on es that included but were ia (1), and dementia (2). recent MDS (minimum data					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495283	B. WING				C 07/18/2019	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-IMPERIAL	STREET ADDRESS, CITY, STATE, ZIP O 1719 BELLEVUE AVENUE RICHMOND, VA 23227		BELLEVUE AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 578	for making daily decise. The clinical record and record) for Resident of Power of Attorney day review of the clinical revidence periodic revidence periodic revidence periodic revidence periodic revidence periodic revidence periodic revidence periodic revidence periodic revidence periodic revidence periodic revidence of attorned with OSM social services directed directives. OSM # 3 social services directives. OSM # 3 social services directives of they want information but if they want resident wants informatione of they want directive OSM # 3 stated on 7/18/19 at 7:43 a. staff member) #1, the	d the EHR (electronic health for 26 revealed a "Durable ated 04/30/2011. Further record and the EHR failed to liew of Resident # 26's mey. b.m., an interview was (other staff member) # 3, or, regarding advance stated, "If they (residents) e directive we don't offer the lask for it we provide it." becifically conduct periodic advance directives to to change anything or if the lation to develop an advance ted, "No."	F	578			8-29-19	
	(administrative staff m administrator, and AS director of nursing, we above findings. No further information References: (1) A swallowing disorobtained from the web	M #2, the administrative are made aware of the was provided prior to exit. der. This information was						

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING			07	C //18/2019
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	IMPERIAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	, 0,	7102013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	sorders.html. (2) A loss of brain fundiseases. It affects mediseases. It affects medideate independent, and behavior obtained from the well-https://medlineplus.go 4. The facility staff fail-Resident #70's (or the decisions regarding at Resident #70's diagnot limited to type 2 diabet (2), and essential hyperset), a quarterly asses (assessment reference Resident #70 as scori assessment for mental	ection that occurs with certain emory, thinking, language, or. This information was osite: v/ency/article/000739.htm. ed to periodically review resident's representative) dvanced directives. nitted to the facility on dmission on 05/27/2019. ses included but were not tes mellitus (1), glaucoma ertension (3). ecent MDS (minimum data sment with an ARD ed date) of 6/30/19, coded	F	578			8-29-1-7
	a social service assess The assessment addre planning and documer health care directive. On 07/17/19 at 3:20 p. conducted with OSM (regarding advance dire they specifically condu- resident's advance dire	m., an interview was other staff member) #3 ectives. When asked if ct periodic reviews of ectives to determine if they no, or if the resident wants			EV.		

PRINTED: 07/30/2019 FORM APPROVED 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 8. WNG 07/18/2019 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 (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 8-29-19 Continued From page 19 F 578 OSM #3 stated, "No," On 7/17/19, OSM #3 submitted a copy of Resident #70's DPOA-HC (durable power of attorney for healthcare) dated 11/30/2017. No evidence of periodic review was noted for advanced directives. On 7/18/19 at 7:43 a.m., ASM (administrative staff member) #1 (the administrator) confirmed periodic reviews of advance directives were not being completed with residents and/or their representatives. On 07/18/19 at approximately 4:40 p.m., ASM # 1 (administrator) and ASM # 2 (the administrative director of nursing) were made aware of the findings. No further information was provided prior to exit. References: 1. diabetes mellitus A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 001214.htm. 2. glaucoma A group of diseases that can damage the eye's optic nerve. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/glaucoma.ht 3. hypertension High blood pressure. This information was

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE COM	
		495283	B. WING		•	C 07/18/2019
	NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-IMPERIAL			STREET ADDRESS, CITY, STATE, ZIP COD 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 578	Continued From page	≥ 20	F 57	78		8-29-19
	obtained from the wel					
	was provided to devel and periodic review w	led to evidence information lop an advance directive ras conducted to provide their resident representative o develop an advance				
	12/08/2018. Resident but were not limited to	mitted to the facility on t #55's diagnoses included o seizures (1), d unspecified dementia (3).				
	set), a quarterly asses (assessment reference Resident # 55 as scor assessment for mental	e date) of 6/18/19, coded				
	a social service asses The assessment addre planning and documer	sment dated 12/17/2018. essed advance directive nted the resident/resident's d information on advance				
	social services director directives. OSM #3 was process for providing in an advance directive to	other staff member) #3, r, regarding advance as asked to describe the nformation for developing				

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI IDENTIFICATION NUMBER: A. BUILDING			NSTRUCTION		ATE SURVEY OMPLETED
		495283	B. WING				C 07/18/2019
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 578	if the resident doesn't stated, "If they don't h we don't offer the info we provide it." When conduct periodic revied directives to determin anything or if the residevelop an advance of "No." On 7/18/19 at 7:43 a. staff member) #1 (the periodic reviews of adbeing completed with representatives. On 07/18/19 at approx (administrator) and As director of nursing) we findings.	already have one. OSM #3 have an advance directive rmation but if they ask for it asked if they specifically haves of resident's advance he if they want to change he dent wants information to hirective OSM #3 stated, m., ASM (administrative hadministrator) confirmed hance directives were not	F	578		5	8-29-19
	the brain. This informativebsite: https://www.nlm.nih.goml. 2. Hyperlipidemia Cholesterol is a fat (alsody needs to work procholesterol can increase heart disease, stroke,	onormal electrical activity in action was obtained from the ov/medlineplus/seizures.ht					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495283	B. WING			C 07/18/2019		
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227			/18/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 578	disorder, hyperlipiden This information was https://medlineplus.go 3. dementia A loss of brain function diseases. It affects mijudgment, and behaviobtained from the well https://medlineplus.go 6. The facility staff fail Resident #45's (or the decisions regarding and Resident #45's diagnor limited to multiple scledementia (2), and maj Resident #45's most rest), a quarterly asses (assessment reference	nia, or hypercholesterolemia. obtained from the website: ov/ency/article/000403.htm. In that occurs with certain emory, thinking, language, or. This information was osite: ov/ency/article/000739.htm. ed to periodically review e resident's representative) dvanced directives. mitted to the facility on dmission on 08/11/2015. oses included but were not crosis (1), unspecified or depressive disorder (3). ecent MDS (minimum data esment with an ARD	F	578			8-29-19	
	assessment for menta of 0 - 15, 0-7 being se daily decisions. Review of Resident #4 a social service asses The assessment addreand documented the rehealthcare POA (power On 07/17/19 at 3:20 p. conducted with OSM (Il status (BIMS) of a score verely impaired for making IS's clinical record revealed sment dated 03/27/2012. essed advance directives esident had a living will and er of attorney).						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
49		495283	B, WING_			C 07/18/2019	
	NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-IMPERIAL			STREET ADDRESS, CITY, STATE, ZIP CO 1719 BELLEVUE AVENUE RICHMOND, VA 23227		0111012013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 578	they specifically cond resident's advance di want to change anyth information to develor #3 stated, "No." On 7/17/19, OSM #3: Resident #45's advanced di On 7/18/19 at 7:43 a. staff member) #1 (the periodic reviews of adbeing completed with representatives. On 07/18/19 at approx (administrator) and As director of nursing) we findings.	uct periodic reviews of rectives to determine if they ing or if the resident wants of an advance directive OSM submitted a copy of the redical directive dated the of periodic review was irrectives. The company of the redical directive dated the of periodic review was irrectives.	F 5	78		8-29-10	
	and spinal cord. It dan the material that surro nerve cells. This dama messages between yo leading to the symptor visual disturbances, m with coordination and las numbness, prickling and thinking and mem information was obtain	* -					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
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		495283	B. WING_		,	07/18/2019
	PROVIDER OR SUPPLIER ARE HEALTH SERVICES	-IMPERIAL		STREET ADDRESS, CITY, STA 1719 BELLEVUE AVENUE RICHMOND, VA 23227	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page	24	F 5	578		8-29-19
	diseases. It affects me judgment, and behavi obtained from the wel https://medlineplus.go 3. depressive disorder Depression may be de blue, unhappy, misera Most of us feel this was short periods. Clinica disorder in which feeli or frustration interfere or more. This information website: https://medlineplus.go 7. The facility staff failicopy of Resident #79's clinical record and faile advance directives with resident's representation.	escribed as feeling sad, able, or down in the dumps. Any at one time or another for a depression is a moodings of sadness, loss, anger, with everyday life for weeks ation was obtained from the everyday life for weeks at one time of the edition of				
	were not limited to stro and insomnia (difficulty most recent MDS (min assessment with an Al	oke, high blood pressure y sleeping). Resident #79's imum data set), an annual RD (assessment reference the resident's cognition as				
	a social services asses 7/2/19. The assessme the patient/patient's de	9's clinical record revealed sment and history dated ent documented, "2. Does cision maker report that has been completed: Yes.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	:	495283	B. WING			_	C 7/18/2019
	NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-IMPERIAL		1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	1 0	77 10/20 (9
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 578	completed: a) DPOA- attorney for health car Resident #79's clinical copy of the DPOA-HO advance directives has reviewed with the resident #31 p.r. conducted with OSM oSM #4 (the social with osm and the admission coordin obtaining a copy of the scanning the copy into On 7/17/19 at 3:20 p.r. conducted with OSM #4 directives. When aske specifically conducts presidents' advance directives. When aske specifically conducts presidents' advance directives. When aske specifically conducts presidents' advance directives. When aske specifically conducts presidents' advance directives. When aske specifically conducts presidents' advance directives. When aske specifically conducts presidents' advance directives. When aske specifically conducts presidents' advance directives. When aske specifically conducts presidents' advance directives. When aske specifically conducts presidents' advance directives. When aske specifically conducts presidents' advance directives. When aske specifically conducts presidents' advance directives. When aske specifically conducts presidents' advance directives. When aske specifically conducts presidents' advance directives. OSM #4 coordinator). OSM #2	HC (durable power of re)" Further review of I record failed to reveal a form and failed to reveal dependent of the periodically dent/representative. In, an interview was (other staff member) #3 and orkers). OSM #3 stated if a directives (such as a living rey) upon admission, then ator is responsible for a advance directives and of the computer system. In, another interview was regarding advance and if the facility staff representatives want to #3 stated, "No."	F	578			8-24-17
	she is supposed to obdirectives, scan the do system and place a cochart.	tain a copy of the advance cuments into the computer py of the documents in the					
	staff member) #1 (the	n., ASM (administrative administrator) confirmed vance directives were not esidents and/or their					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING		. ,,.,		/18/2019
,	NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-IMPERIAL			1	STREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	On 7/18/19 at 9:44 a.i facility did not have a advance directives. V advance directives sh resident's clinical reco "Absolutely." On 7/18/19 at 11:55 a administrative director (the quality assurance aware of the above co No further information. 8. The facility staff fail copy of Resident #248 the clinical record. Resident #248 was ac 7/10/19. Resident #24 were not limited to dia and repeated falls. Re MDS (minimum data s nursing admission ass	m., ASM #1 confirmed the copy of Resident #79's When asked if a copy of ould be a part of a ord, ASM #1 stated, .m., ASM #1, ASM #2 (the of nursing) and ASM #3 e consultant) were made	F	578			૪- 2૧- ૧ ૧
	Review of Resident #2 revealed a social servi history dated 7/15/19. documented, "2. Does decision maker report has been completed: \(\) planning has been cor (durable power of attor Further review of Resident as social services with the social services and the social services with the social services and the social services as the social services are social services as the social services are social services.	ces assessment and The assessment the patient/patient's that advance care planning Yes. 3. What advance care					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING			07	//18/2019	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-IMPERIAL	•		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 578	On 7/17/19 at 1:31 p.i conducted with OSM OSM #4 (the social with resident has advance will or power of attornative admission coordination obtaining a copy of the scanning the copy into On 7/18/19 at 8:49 a.r. conducted with OSM accordinator). OSM #2 advance directives in a she is supposed to obtain directives, scan the dosystem and place a cochart. On 7/18/19 at 9:44 a.m. staff member) #1 (the the facility did not have	m., an interview was (other staff member) #3 and orkers). OSM #3 stated if a directives (such as a living ey) upon admission, then later is responsible for e advance directives and othe computer system. m., an interview was #2 (the admission e stated if a resident has place upon admission, then tain a copy of the advance becomments into the computer opy of the documents in the m., ASM (administrative administrator) confirmed e a copy of Resident #248's fren asked if a copy of ould be a part of a	F	578			8-29-19	
	administrative director (the quality assurance aware of the above co No further information 9. The facility staff faile	was presented prior to exit.						
	clinical record and faile	advance directives on the ed to periodically review on the resident and/or the ed.	3					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED
		495283	B. WING			ĺ	C
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE		07/18/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 578	Resident #39 was adr 6/19/14. Resident #39 were not limited to hig pressure and difficulty #39's most recent MD annual assessment w reference date) of 6/1, cognition as severely Review of Resident #3 a social services asse 5/30/19. The assessm the patient/patient's de advance care planning 3. What advance care completed: a) DPOA-1 attorney for health care Resident #39's clinical copy of the DPOA-HC advance directives had reviewed with the resident On 7/17/19 at 1:31 p.m. conducted with OSM (OSM #4 (the social wo	mitted to the facility on 9's diagnoses included but th cholesterol, high blood of swallowing. Resident 9's (minimum data set), an ith an ARD (assessment /19, coded the resident's impaired. 39's clinical record revealed essment and history dated ment documented, "2. Does recision maker report that g has been completed: Yes. In planning has been HC (durable power of record failed to reveal a form and failed to reveal d been periodically dent/representative. In., an interview was other staff member) #3 and orkers). OSM #3 stated if a	F	578			8-29-19
	will or power of attorne the admission coordina obtaining a copy of the scanning the copy into On 7/17/19 at 3:20 p.m conducted with OSM # directives. When aske specifically conducts por residents' advance directives.	e advance directives and the computer system. n., another interview was a regarding advance and if the facility staff eriodic reviews of ectives to determine if epresentatives want to					

B. WING	STREET ADDRESS, CITY, STATE, ZIP CO 1719 BELLEVUE AVENUE RICHMOND, VA 23227	C 07/18/2019
ULL PRE	STREET ADDRESS, CITY, STATE, ZIP CO 1719 BELLEVUE AVENUE RICHMOND, VA 23227	
ULL PRE	1719 BELLEVUE AVENUE RICHMOND, VA 23227	DDE
ULL PRE	PROVIDER'S PLAN OF C	
IAV	FIX (EACH CORRECTIVE ACTIO	ON SHOULD BE COMPLETION BE APPROPRIATE DATE
as , then ance aputer in the re ned not the s f (the	578	8-29-19
o exit. e a n the w he		
i i i	#3 e exit. e a n the w ne	e exit. e a in the wine but

STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' ' -	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING) DATE SURVEY COMPLETED	
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		495283	B. WING			0.	C 7/18/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		710/2015	
				.	1719 BELLEVUE AVENUE			
MANORC	ARE HEALTH SERVICES	S-IMPERIAL		Ы	RICHMOND, VA 23227			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION	
F 578	Continued From Dage	- 20					8-29-19	
F 5/6			F	578				
		recent MDS (minimum data	Ì				1	
	set), a quarterly asse							
		ce date) of 6/23/19, coded						
		e skills for daily decision	-					
	making as severely in	npaired.			İ			
	Review of Resident #	64's clinical record revealed						
		essment and history dated						
		ent documented, "2. Does					1	
		ecision maker report that						
		g has been completed: Yes.						
	3. What advance care		1					
ļ		HC (durable power of			52			
i	attorney for health car	re)" Further review of					1	
	Resident #64's clinica	I record failed to reveal a						
	copy of the DPOA-HC	form and failed to reveal						
	advance directives ha	d been periodically						
[reviewed with the resi	dent/representative.						
	On 7/17/19 at 1:31 p.r	n., an interview was						
	conducted with OSM ((other staff member) #3 and	İ					
	OSM #4 (the social we	orkers). OSM #3 stated if a	İ					
	resident has advance	directives (such as a living						
		ey) upon admission, then	ŀ					
i	the admission coordin							
		e advance directives and						
	scanning the copy into	the computer system.		į				
	On 7/17/19 at 3:20 n n	n., another interview was						
	conducted with OSM #	-						
	directives. When aske							
	specifically conducts p	•					-	
	-	ectives to determine if						
		representatives want to						
	change anything OSM						50.5	
1.	On 7/19/10 at 9:40 a =	a an intonious was					1.1	
	On 7/18/19 at 8:49 a.n conducted with OSM #			-			1	
		stated if a resident has	1					
- 11	COGIUITIALOI). OSIVI #2	Stated II a resident fias	1	- 1			I	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '				DATE SURVEY COMPLETED	
		495283	B. WING			07	C
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-IMPERIAL					STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	<u> </u>	7/18/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 578	advance directives in she is supposed to obtain the directives, scan the disystem and place a chart. On 7/18/19 at 7:43 a. staff member) #1 (the periodic reviews of acheing completed with representatives. On 7/18/19 at 9:44 a. facility did not have a advance directives. Vadvance directives she resident's clinical reconstant and the periodic reviews of acheing completed with representatives. On 7/18/19 at 11:55 a administrative director (the quality assurance aware of the above constant to the director of the above constant to the director of the above constant the director of the directo	place upon admission, then obtain a copy of the advance ocuments into the computer opy of the documents in the om., ASM (administrative administrator) confirmed livance directives were not residents and/or their one., ASM #1 confirmed the copy of Resident #64's When asked if a copy of ould be a part of a ord, ASM #1 stated, ord, ASM #1, ASM #2 (the of nursing) and ASM #3 e consultant) were made	F	578			8-29-19
	reviews of the advance #40 and or the resider Resident #40 was adm 9/27/17, with a recent with diagnoses that into: stroke, dementia, a The most recent MDS assessment, a quarter	nitted to the facility on readmission on 4/26/19, cluded but were not limited and high blood pressure. (minimum data set) ly assessment, with an date of 6/4/19, coded the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SUI COMPLET			
		495283	B. WING			C		
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES			DDE .	07/18/2019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	resident was severely cognitive decisions. Review of the clinical Services Assessment 4/29/19. The form doc "Advanced Care Plan his/her own decisions patient/patient's decis advance care plannin What advance care plannin What advance care plannin What advance care planning - NO." Review of the clinical durable power of attor resident did have a pomatters but not health On 07/17/19 at 3:20 p conducted with OSM (social services directed directives. OSM #3 w	record, revealed a "Social and History" dated, cumented in part, ning: Does the patient make a no. Does the sion maker report that g has been completed yes. lanning has been completed a power of attorney for a patient/patient's decision on advance care record failed to evidence a mey for health care. The ower of attorney for financial acare. .m., an interview was (other staff member) # 3,	F 578			8-29~19		
	an advance directive tresident's representati if the resident doesn't 3 stated, "If they don't we don't offer the inforwe provide it." When conduct periodic reviedirectives to determine anything or if the resideresidentation."							
- 1	On 7/18/19 at 7:43 a.n	n., ASM (administrative		85				

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		1.	ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
			1,00,120				c
		496283	B. WING			07	/18/2019
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-IMPERIAL		1	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578	staff member) #1 (the periodic reviews of adbeing completed with representatives. On 7/18/19 at 9:44 a.r facility had the copy of attorney for financial recare decisions. Administrative staff meadministrator, ASM #2	administrator) confirmed livance directives were not residents and/or their m., ASM #1 confirmed the f Resident #40's power of natters but not for health ember (ASM) #1, the 2, the administrative director #3, the quality assurance e aware of the above	F	578			8-29-19
,	(1) Barron's Dictionary Non-Medical Reader, Chapman, page 55. Notify of Changes (Inj CFR(s): 483.10(g)(14) §483.10(g)(14) Notifica		F	580	F= 580 The statements made on this plan of correction are not an admission to and	=	8-29-19
	consult with the reside consistent with his or a representative(s) where (A) An accident involving results in injury and has physician intervention; (B) A significant changemental, or psychosocial deterioration in health, status in either life-threclinical complications);	ent's physician; and notify, ther authority, the resident in there isting the resident which as the potential for requiring the in the resident's physical, all status (that is, a mental, or psychosocial eatening conditions or			do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	I	495283	B. WING			1 03	7/18/2019
NAME OF P	ROVIDER OR SUPPLIER			Т	STREET ADDRESS, CITY, STATE, ZIP CODE		10,2010
				ı	1719 BELLEVUE AVENUE		
MANORC	ARE HEALTH SERVICES	-IMPERIAL		RICHMOND, VA 23227			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTION		700
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	ΙX	(EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
	a need to discontinue treatment due to adverse commence a new form (D) A decision to transpected from the facility 483.15(c)(1)(ii). (ii) When making notify (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must all resident and the resi	an existing form of the erse consequences, or to an of treatment); or size or discharge the sity as specified in size of the facility must ensure that an specified in §483.15(c)(2) led upon request to the sent representative, if any, or roommate assignment O(e)(6); or an trights under Federal or as as specified in paragraph second and periodically railing and email) and esident site distinct part (as defined in in its admission agreement on, including the various as the composite distinct the policies that apply to	F	58	the following plan of correction constitutes the center's allegation compliance. All alleged deficiencie cited have been or will be corrected the date or dates indicated It is the intended practice of this faci to notify the Physician and/or responsible party of a change in condition. 1. On December 24, 2018, resident 39's representative was notified change in condition due to a UTI well as the added antibiotic on December 22, 2018. 2. Residents who have a change in condition/medication have the potential to be affected. 3. Director of Nursing and/or design will conduct re-education for Licensed nurses on the facility guidelines on notifying of change conditions and notifying of change in medications to patient representatives. 4. Director of Nursing and/or design will audit residents who have had change in condition daily x 5 day then three days a week x 3 week and then monthly x 2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations w be discussed and implemented a needed.	s by lity # of as neee in ge ee a s.s.	8-29-19
	This REQUIREMENT by: Based on staff intervie review, clinical record r	eview, and in the course of on, it was determined that			5. The facility's alleged date of compliance will be August 29, 201	9.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	PLE CONSTRUCTION		ATE SURVEY OMPLETED	
		495283	B. WING			C 07/18/2019	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-IMPERIAL .		STREET ADDRESS, CITY, STATE, ZIP CO 1719 BELLEVUE AVENUE RICHMOND, VA 23227		0710/2013	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
	representative of a channed to alter treatment the survey sample, Rounders The findings include: The findings include: The facility staff failed representative when the with a urinary tract informedication was initiated. Resident #39 was addressure and difficulty #39's most recent MD annual assessment was reference date) of 6/1/2 cognition as severely. Review of Resident #3 a physician's order date (1) 100 mg (milligrams).	to notify Resident #39's he resident was diagnosed ection and antibiotic ed. mitted to the facility on 9's diagnoses included but h cholesterol, high blood swallowing. Resident S (minimum data set), an ith an ARD (assessment 1/19, coded the resident's	F 58	0		8-39-19	
	check done. Resident 3x's (times) a day for to infection)" Further re- clinical record failed to Resident #39's represent of the diagnosis of a U Macrobid. Resident #	eview of Resident #39's reveal documentation that entative was made aware 'TI or the initiation of 39's comprehensive care ed to document information					
	On 7/18/19 at 10:41 a. conducted with RN (re was asked if a residen						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
l		495283	B. WING			07	C 7/18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVICES	-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	10,	710/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	UTI and when antibion RN #3 stated, "Yes." stated, "So the family placed on an antibiotic infection." On 7/18/19 at 11:55 a staff member) #1 (the (the administrative din #3 (the quality assural aware of the above concent to the facility document CONDITION" docume for Medicare and Medifacility must immediate consult with the residence consistent with his or in representative(s) when change in the resident psychosocial status	tic medication is initiated. When asked why, RN #3 will know they have been of for a urinary tract .m., ASM (administrative administrator), ASM #2 ector of nursing) and ASM noce consultant) were made encern. titled, "CHANGE IN nted, "CMS (The Centers icaid Services) requires, 'A ely inform the resident; ent's physician; and notify, her authority, the resident in there is: A significant by sphysical, mental, or A need to alter treatment was presented prior to exit.	F	580			8-29-19
	(1) Macrobid is used to information was obtain https://medlineplus.govtml Personal Privacy/Confic CFR(s): 483.10(h)(1)-(§483.10(h) Privacy and The resident has a right	e treat infections. This ed from the website: //druginfo/meds/a682291.h //dentiality of Records 3)(i)(ii)	F5	583	F – 583. The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal		8-29-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		495283	B. WING			07	/18/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
MANORO	ARE HEALTH SERVICES	JMDEDIAL		١ ٠	1719 BELLEVUE AVENUE			
MANORO	AND HEADIN SERVICES	HINTERIAL		1	RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE	
			1				8-29-19	
F 583	Continued From page	37	F:	583				
	***				and state regulations, the center has	;		
	§483.10(h)(l) Persona	l privacy includes			taken or will take the actions set forth	in		
	accommodations, med	dical treatment, written and			the following plan of correction			
		tions, personal care, visits,			constitutes the center's allegation of	•		
		y and resident groups, but			compliance. All alleged deficiencies cited have been or will be corrected b			
	this does not require to				the date or dates indicated	,	i i	
	private room for each	resident.						
	§483.10(h)(2) The faci	ility must respect the			It is the intended practice of this facilit to protect the personal privacy and	.y	1	
		onal privacy, including the			confidentiality of medical records.			
		or her oral (that is, spoken),	Ì		i i i i i i i i i i i i i i i i i i i			
1		communications, including	-				ļ I	
		romptly receive unopened	-		1. Upon notification			
1	mail and other letters,	packages and other			of surveyor, the lis	t		
	materials delivered to	the facility for the resident,	!		of resident names			
		ed through a means other			was turned over by	,		
	than a postal service.				RN #7 to protect			
					patient			
İ		dent has a right to secure			confidentiality.		} I	
	-	nal and medical records.			2. All residents who reside in the facility		l ł	
- 1	of personal and medical	e right to refuse the release	Ī		have the potential	′		
	provided at §483.70(i)(to be affected.			
	federal or state laws.	2) or other applicable			3. Director of Nursing			
		ow representatives of the			and/or designee			
		g-Term Care Ombudsman	<u> </u>		will conduct			
	to examine a resident's				education with the			
		in accordance with State			Nursing staff on			
	law.		İ		confidentiality of resident records.			
		is not met as evidenced			resource records.			
}	by:	and staff into a de	1]	
Ì	Daseu on observation	and staff interview, it was					l I	
	determined the facility s	starr railed to maintain nt information on one of						
	two units, Unit 2.	in anomation on the tr						
	one writing writing							
			j	ļ			' <u> </u>	
	The findings include:		İ			j		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	2) MULTIPLE CONSTRUCTION BUILDING		E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 07	/18/2019
MANORC	ARE HEALTH SERVICES	-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 CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	The facility staff failed resident information wo others. Observation was mad Unit two on 7/17/19 at with 22 resident name medical information wo cart, face up. The paproom numbers, if the taken whole or crushed blood sugar readings feeding information, a residents had. There with emedication cart. RN (registered nurse) medication cart on 7/1 immediately turned the why the piece of pape cart was a concern, Ri "Confidentiality."	to ensure a document with vas protected from view of the medication cart on a 3:00 p.m. A piece of paper is on it with documented as located on top of the er listed residents names, medications were to be id, blood pressure readings, with insulin given, tube and appointments the were no staff members near #2 returned to her 7/19 at 3:05 p.m. She is paper over. When asked on top of the medication N #2 stated,	F5	4. Director of Nu and/or designe will complete random audit of nursing units to ensure patient record confidentiality in x 5 days, then to days a week x 3 weeks and there monthly x 2 months. Results the QAA audits be reviewed by facility's QAA Committee. Recommendat will be discussed and implement as needed. 5. The facility's alleged date of compliance will August 29, 201.	daily three s of will y the ions ed	8-29-19
F 622 SS=E	the quality assurance of aware of the above con p.m.	of nursing, and ASM #3, consultant were made neerns on 7/17/19 at 4:50 was obtained prior to exit. Requirements (ii)(2)(i)-(iii)	F 62	F 622 The statements made on this please correction are not an admission do not constitute an agreement the alleged deficiencies cited her remain in compliance with all fecand state regulations, the center	to and within ein. To ederal	J-29-19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING		"		
		495283	B. WING			C 7/18/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				1719 BELLEVUE AVENUE			
MANORCA	ARE HEALTH SERVICES	-IMPERIAL		RICHMOND, VA 23227			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION	
				the following plan of corr	rection	8-29-10	
F 622	Continued From page	39	F 62	constitutes the center's alle			
	§483.15(c)(1) Facility	requirements-		compliance. All alleged dej			
- 1	(i) The facility must pe	•		cited have been or will be co			
	remain in the facility, a			the date or dates indica	•		
		t from the facility unless-		THE WOLL OF WOLLS HIME	-		
		charge is necessary for the		It is the intended practice of	this facility		
l	resident's welfare and	-		to provide evidence that a r	esident's	1	
	cannot be met in the fa			documentation and informa	ation was		
1				provided to a receiving provi	der upon a	1	
	(B) The transfer or dis because the resident's			facility initiated transfer to a	hospital.		
		dent no longer needs the		1. Upon notification from s	urveyor on		
	services provided by the			7-18-19, Administrative	Nursing		
1	(C) The safety of indiv	**		staff were educated on	=		
	endangered due to the		1	clinical documentatio	n to be		
	status of the resident:			included at time of trans	fer by the		
	•	iduals in the facility would	-	Administrator.	·		
	otherwise be endange			2. Residents that the facilit	y initiated		
		ailed, after reasonable and		a transfer to the hospita	*		
		pay for (or to have paid	1	potential to be affe			
				3. Director of Nursing			
		dicaid) a stay at the facility.		designee re-educated	-		
	Nonpayment applies if		ŀ	Nurses on the Acute Care			
	* *	paperwork for third party		Documentation Checklist		1	
1	payment or after the th			į .	=		
		denies the claim and the	1	to make sure to provide documentation to the r		1	
		for his or her stay. For a	İ	provider upon a facility	-	}	
		eligible for Medicaid after	-	transfer to a hospi		1	
		the facility may charge a	 	4. Director of Nursing a		+	
	•	charges under Medicaid;		designee will audit any a	•	1	
i	or		1	transfers daily x 5 days, tl			
	(F) The facility ceases	· · · · · ·	-	a week x 3 Weeks and the	•		
] ((ii) The facility may not	transfer or discharge the	1	x 2 months. Results of	•		
[1	resident while the appe	eal is pending, pursuant to	1	1			
	§ 431.230 of this chapt	er, when a resident		audits will be reviewed	•		
		ht to appeal a transfer or		facility's QAA Comm		J	
		he facility pursuant to §		Recommendations will be		i	
		napter, unless the failure to		and implemented as n			
		ould endanger the health		5. The facility alleged d			
		t or other individuals in the		compliance is August 2	9, 2019.	1	
I	•	st document the danger	1			1	
1 8	women, the facility fills	or accomment me named					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUC		(X3) DATE SURVEY COMPLETED			
		495283	B. WING				C 07/18/2019	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-IMPERIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORF EACH CORRECTIVE ACTION S COSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	that failure to transfer §483.15(c)(2) Docume When the facility trans resident under any of in paragraphs (c)(1)(i) section, the facility may or discharge is documedical record and approximation or provider. (i) Documentation in the must include: (A) The basis for the te (i) of this section. (B) In the case of para section, the specific re be met, facility attemp needs, and the service facility to meet the need (ii) The documentation (2)(i) of this section me (A) The resident's phy- discharge is necessary (A) or (B) of this section	entation. sfers or discharges a the circumstances specified (A) through (F) of this ust ensure that the transfer mented in the resident's propriate information is receiving health care the resident's medical record transfer per paragraph (c)(1) to graph (c)(1)(i)(A) of this esident need(s) that cannot tes to meet the resident e available at the receiving ed(s). In required by paragraph (c) ust be made by- sician when transfer or y under paragraph (c) (1)	F	522			8-29-19	
81	necessary under paragethis section. (iii) Information provide must include a minimu (A) Contact information responsible for the car	graph (c)(1)(i)(C) or (D) of ed to the receiving provider m of the following: n of the practitioner e of the resident. tative information including information ons or precautions for opriate.						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495283	B. WING				С	
NAME OF P	ROVIDER OR SUPPLIER	430203	B. VIIIVO	STREET ADDRESS, (CITY, STATE, ZIP CODE	07	//18/2019	
MANORC	ARE HEALTH SERVICES	-IMPERIAL		1719 BELLEVUE AV RICHMOND, VA				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	OVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 622	-		F	522			8-29-19	
	copy of the resident's consistent with §483.2 any other documental a safe and effective tr This REQUIREMENT by: Based on staff intervi and clinical record reviacility staff failed to edocumentation was preacility upon facility inithospital for eight of 54 sample, Residents #4 #59 and #70. The findings include: 1. The facility staff failed the required documentation receiving hospital for fithe hospital on 4/25/19. Resident #40 was admitted.	21(c)(2) as applicable, and ion, as applicable, to ensure ansition of care. is not met as evidenced ew, facility document review iew, it was determined the nsure the required rovided to the receiving tiated transfer to the residents in the survey 0, #21, #7, #24, #78, #44, ed to provide evidence that tation was sent to the Resident #40's transfer to 9.						
	to: stroke, dementia, a The most recent MDS assessment, a quarter assessment reference resident as scoring a " interview for mental sta	ly assessment, with an date of 6/4/19, coded the						
		d, 4/25/19, documented, pital) for peg tube (feeding						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION		ATE SURVEY	
		1	,		İ	С
		495283	B. WING	<u> </u>	. .	07/18/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		07710/2019
				1719 BELLEVUE AVENUE		
MANORCA	ARE HEALTH SERVICE	ES-IMPERIAL		RICHMOND, VA 23227		
O(A) ID	SUMMARY	STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	PRECTION	0/6
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
						8-29-19
F 622	Continued From page	ge 42	F 622	2		
		ted, 4/25/19 at 2:38 a.m.	i			ļ
	documented "Went	to resident room to change				
	peg tube dressing a	nd found peg tube fully				
		peside him in the bedMD				
		ified received order to send to				
	(name of hospital) for	or peg tube replacement. Call	- [
		nsible party) left message on				
	voicemail. Transport	ted to (name of hospital)."				
i	An interview was co	nducted with RN (registered				
		at 3:05 p.m. RN #2 was	1			
		cess staff follows when a				
	•	to the hospital. RN #2 sated,	1			
		through the DON (director of				
		kay to transfer and then notify				
		a transfer form to fill in; we				İ
		the ambulance." When	i			
		y evidences what information				
		pital, RN #2 stated, "It should				
		d, the transfer form. And we				
		nent in the nurses' notes."				İ
		the comprehensive care plan	-			
		esidents to the hospital, RN				}
		t. I just do the current meds	1			
		16 p.m., RN #2 presented a				1
	checklist of what is s					
	The paper presented	by RN #2 titled "Post-Acute				
		nent Checklist" documented,				[
		atient (Check all that apply).				1
		ould always accompany	1			
1		sition of care form. Face				1
		and physical) or Admission				
		conciliation Form. Current				1
1 '	· · · · · · · · · · · · · · · · · · ·	irrent MAR (medication				1
		l). Advances (sic) directives.				1
		ician's assistant)/NP(nurse				1
		elated to acute condition (last				1
		ab (laboratory) results.				

STATEMENT OF DEFIGIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				ATE SURVEY OMPLETED			
		495283	B. WING			Ì	C 07/18/2019
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 622	Relevant x-ray report sent with the patient. placed in the medical transfer - copy sent wo for transfer - copy of Care Personal belongings eyeglasses, hearing at An interview was conpractical nurse) #1 or regarding documental transfer. LPN #1 state everything on the cheprovided the above of When asked how the sent with the resident EMT (emergency medical form and then copy it record."	s. Bed hold policy - copy Bed hold policy - copy record. Notification of vith the patient. Notification ced in the resident medical plan Sent with patient. sent with patient, aide, or dental appliance." ducted with LPN (licensed 17/17/19 at 3:36 p.m. tion sent with a resident on ed, "The transfer form, and	F	622			8-29-19
	completed before sur prior." The facility policy for a	r to survey but it was not yey, we had identified this admission and transfers was					
	No policy was present The administrator, add (ASM) #1, and ASM # director of nursing, an assurance consultant, above concern on 7/13	ministrative staff member 2, the administrative d ASM #3, the quality were made aware of the					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		TE SURVEY MPLETED
		495283	B. WING			07	C
NAME OF	PROVIDER OR SUPPLIER		' 	S	TREET ADDRESS, CITY, STATE, ZIP CODE	0/	/18/2019
			J		719 BELLEVUE AVENUE		
MANOR	CARE HEALTH SERVI	CES-IMPERIAL			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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	Continued From page	ge 44	F6	22			8-29-19
	the required documereceiving hospital for the hospital on 3/30,						
	3/9/18 with a recent diagnoses that inclu diabetes, depression The most recent ME assessment, a Medi with an assessment coded the resident a (brief interview for mediagnoses).	dmitted to the facility on readmission on 4/4/19, with ded but were not limited to: n, and high blood pressure. OS (minimum data set) care 30 day assessment, reference date of 4/30/19, as scoring a "15" on the BIMS pental status) score, indicating making daily cognitive					
	documented in part, very lethargic, alert a did not eat dinner, re Vital signs 100.8 (ter	ed, 3/30/19 at 11:06 p.m. "Resident was found to be and not responding to verbal, fuse to take her medications." "The state of the stat					
	(oxygen) saturation of (medical doctor) was received. Resident a were oriented to the facility, resident is go was called and reside	of 85% on room air. MD is notified order to transfer out and R/P (responsible party) diagnosis and the acute care ing to. Emergency response ent was transported to (name 11:00 p.m.) Bed hold					
		dated, 3/30/19 at 11:23 p.m. he resident to (name of on."					
- 1,	An interview was con	ducted with RN (registered					1

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495283	B. WING			07	C /18/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, (CITY, STATE, ZIP CODE	1 07	/10/2019
MANOR	CARE HEALTH SERVI	CES-IMPERIAL		1719 BELLEVUE A			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	how the facility evidesent to the hospital, was completed, the always document in was asked if the core are sent with reside stated, "No, I don't. (medications)." At 3 checklist of what is a checklist of wh	at 3:05 p.m. When asked ences what information was RN #2 stated, "It should say it transfer form. And we should the nurses' notes." RN #2 mprehensive care plan goals ints to the hospital, RN #2 I just do the current meds into the p.m., RN #2 presented a	F	22			8-29-19
	sent with the patient, placed in the medica transfer - copy sent to of transfer - copy pla record. Copy of Care Personal belongings eyeglasses, hearing 07/18/19 at 11:50 a.r. not have the check lican evidence what wastarted education prices.	Bed hold policy - copy Il record. Notification of with the patient. Notification ced in the resident medical plan Sent with patient.					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING			0.	C 7/18/2019
NAME OF	PROVIDER OR SUPPLIER		<u>. </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	7710/2019
MANOR	CARE HEALTH SERV	ICES-IMPERIAL			719 BELLEVUE AVENUE ICHMOND, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 622	Continued From pa	ge 46	Fe	22		_	8-29-19
	(ASM) #1, and ASM director of nursing, assurance consulta above concern on 7 No further informati 3. The facility staff f the required docum receiving hospital for hospital on 5/19/19. Resident #7 was ad 10/11/18 with diagnout limited to: multip disease in which ne spinal cord lose their disorder, morbid obe depression. The modata set) assessment with an assessment	on was obtained prior to exit. ailed to provide evidence that entation was sent to the providence that entation was sent to the providence and the existence of the facility on poses that included but were ple sclerosis [a progressive right providence of the brain and providence of the brain and providence of the pro					
	(brief interview for m	ns scoring a "15" on the BIMS nental status) score, indicating pable of making daily		1			
8 1	documented, "Husba concerned for patien half due to nausea a her medications. Pat nurse that she is hav to her shoulders." The 5/19/19 at 3:24 p.m. doctor) notified on ca	ted, 5/19/19 at 2:34 p.m. and came to nurse's station at hasn't eaten past day and and vomiting, and is refusing tient did relay to the other ring mid sternal pain radiating are nurse's note dated, documented, "(Name of all by RN (registered nurse), o go to ER. Husband wanting					

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILO		E CONSTRUCTION		OATE SURVEY OMPLETED
İ		495283	B. WING	i			C 07/18/2019
	PROVIDER OR SUPPLIER	ICES-IMPERIAL		17	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE CHMOND, VA 23227		11110/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	ambulance compar Patient went via am ER (emergency roo An interview was conurse #2 on 7/17/19 how the facility evid sent to the hospital, was completed, the always document in was asked if the con are sent with reside stated, "No, I don't. (medications)." At 3 checklist of what is a The paper presente Care Transfer Docu "Copies Sent with P. These documents s Patient: Patient trans Sheet. H&P (history Note. Medication Re	ials of hospital, (Name of my) called and on their way. Industrial with the industrial way. Industrial with the industrial was a stated, "It should say it transfer form. And we should the nurses' notes." RN #2 mprehensive care plan goals into the hospital, RN #2 I just do the current meds in the industrial was a stated. The industrial was a stated with the industrial was a stated. The industrial was a stated with the industri	F	522			8-29-19
	administration recome Recent MD/PA (physical practitioner) orders in 48 hours). Relevant Relevant x-ray reports and with the patient placed in the medical transfer - copy sent with transfer - copy of transfer - copy of Care Personal belongings eyeglasses, hearing	d). Advances (sic) directives. sician's assistant)/NP (nurse related to acute condition (last lab (laboratory) results. ts. Bed hold policy - copy. Bed hold policy - copy at record. Notification of with the patient. Notification aced in the resident medical e plan Sent with patient.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
ļ							С
		495283	B. WING	<u>' — </u>		07.	/18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-IMPERIAL		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED 8Y FULL SC 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 622	not have the check can evidence what started education p completed before s prior." The administrator, a (ASM) #1, and ASM director of nursing, assurance consulta above concern on 7 No further information (1) Barron's Dictiona Non-Medical Reade Chapman, page 380 4. The facility staff frequired documenta provided to the rece facility-initiated transfor Resident # 24.	lists, so there is no way we went to the hospital. We rior to survey but it was not urvey, we had identified this administrative staff member #2, the administrative and ASM #3, the quality nt, were made aware of the /18/19 at 4:25 p.m. on was obtained prior to exit. ary of Medical Terms for the r, 5th edition, Rothenberg and 0. failed to evidence that all tion and information was iving provider for a sifer on 03/29/19 and 05/10/19	F	622			8-29-19
	03/14/19 with diagnor not limited to cerebra mellitus (2). Resider (minimum data set), assessment with an date) of 05/06/19, coscoring a nine on the status (BIMS) of a somoderately impaired decisions.	dmitted to the facility on oses that included but were all infarction (1), and diabetes at # 24's most recent MDS a significant change ARD (assessment reference oded Resident # 24 as a brief interview for mental core of 0 - 15, nine - being of cognition for making daily					
1	for Resident # 24 do	ss Notes," dated 03/29/2019 cumented, "21:06 (9:06 p.m.) eeing NP (nurse practitioner)					

AND PLAN OF CORRECTION INFORMATION AND MADED.			X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING	i	_	1	C
	PROVIDER OR SUPPLIER		.!-	171	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE CHMOND, VA 23227	<u> </u>	<u>/18/2019</u>
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	this evening, ordere (Name of Hospital) (responsible party) situation. Resident The nurse's "Progre for Resident # 24 do a.m.) Resident adm admission assessm completed by previous copy and paste to copy and pa	ge 49 d to transfer resident to for further observation. RP (sister) made aware of was alert, denies pain." ss Notes," dated 04/03/2019 ocumented,"10:31 (10:31 itted on 4/2/19 to facility, ent and documentation ous charge nurse, admission orrect medical number. the facility via (by) stretcher ss Notes," dated 05/10/2019 ocumented the resident was or evaluation after staff noted on-responsive. The entry "NP in building evaluated o send to er (emergency on RP (responsible party) was lent changed in condition and of Hospital) for evaluation." Lifecord and the FHR	F	522			8-29-19
	(electronic health red to evidence docume information was provat the tie of Resident and 5/10/19. There Resident # 24's cont practitioner responsi resident, resident rej including contact info documentation evide Directive information precautions for ongo comprehensive care	cord) for Resident # 24 failed intation that all required vided to the receiving hospital at #24's transfer on 3/29/19 was no evidence that act information of the ble for the care of the presentative information, ormation was provided. No encing the residents Advance all special instructions or ing care, as appropriate,					

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

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495283	B. WING			0.7	C
NAME OF PROVID		ICES-IMPERIAL		STREET ADDRESS, CITY, 1719 BELLEVUE AVENU RICHMOND, VA 2322	JE	1 07	/18/2019
(X4) ID PREFIX (TAG R	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	iD PREFI) TAG	ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
reside the restrans On 7/condivegar they set transionable fax con	deceiving facility fer. 717/19 at 1:32 Jucted with OSI ding hospitalize and anything fer, OSM #3 stroker. 717/19, a required to acute for the facility of th	p.m., an interview was M (other staff member) #3, ration process. When asked if to the receiving provider upon rated, "We send a fax to the rive a book where we keep a ave a folder-checklist when recare." rest was made to ASM member) #1, the recumentation that the required at to the receiving provider for rester to the hospital on	F 6	22			8-29-19

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495283	B. WING		ŀ	C 07/18/2019
	PROVIDER OR SUPPLIER	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP COD 1719 BELLEVUE AVENUE RICHMOND, VA 23227		07/16/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SECTION OF CROSS-REFERENCED TO THE APDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
ja .	few seconds, the broxygen. Brain cells damage. This informediate: https://medlineplus. (2) A chronic diseas regulate the amount information was obth https://www.nlm.nih.001214.htm. 5. The facility staff frequired documental provided to the recefacility-initiated trans #78. Resident # 78 was a 11/29/17 and a read diagnoses that incluhypertension (1), and Resident # 78's mosset), a 14-Day asses (assessment references Resident # 78 as sociate the sociate that including the second for making daily decomplete that the second for the nurse's "Progres for Resident # 78 do (5:19 p.m.). Resider approval was sent to sodium level and del (by) ambulance @ (asserted for the clinical formation of the clinical formation of the clinical formation of the clinical formation of the clinical few formations of th	ain cannot get nutrients and can die, causing lasting nation was obtained from the gov/ency/article/000726.htm. e in which the body cannot of sugar in the blood. This ained from the website: gov/medlineplus/ency/article/dialed to evidence that all tion and information was iving provider for a offer on 06/26/19 for Resident dialetted to the facility on mitted on 06/30/19 with ded but were not limited to diabetes mellitus (2). It recent MDS (minimum data of sament with an ARD offer on 07/14/19, coded oring a three on the brief status (BIMS) of a score of 0 everely impaired of cognition	F 62	22		8-59-19

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		495283	B. WING	<u>(</u>)		C
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		7/18/2019
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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	to evidence docume information was pro at the time of Reside hospital on 6/26/19. On 7/17/19 at 1:32 producted with OSM regarding hospitalizatine send anything they send anything they send anything they send anything they send anything they send anything they send anything they send anything they send anything they send anything they send anything they send anything they send anything transfer, OSM #3 strombudsman, we have transferring to acute On 07/17/19, a requipal (administrative staff administrative staff administrative staff administrative staff and they are they ar	entation that the required vide to the receiving hospital ent #78's transfer to the o.m., an interview was M (other staff member) #3, ation process. When asked if to the receiving provider upon ated, "We send a fax to the ve a book where we keep a ave a folder-checklist when a care." est was made to ASM member) #1, the cumentation that required to the receiving provider # 78's transfer to the hospital m., ASM #1 stated, "We do ists, so there is no way you went to the hospital. We for to survey but not arvey, we had identified this oximately 5:00 p.m., ASM	F 62			8-29-19
	above findings.	rere made aware of the n was provided prior to exit.				
į		ure. This information was				

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

AND PLAN OF CORRECTION (X1) PHOVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495283	B. WING _			C	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		7/18/2019	
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILO BE	(X5) COMPLETION DATE	
	https://www.nlm.nih essure.html. (2) A chronic diseas regulate the amount information was obt https://www.nlm.nih 001214.htm. 6. The facility staff of required documental provided to the recefacility-initiated trans # 44. Resident # 44 was a 02/17/14 and a read diagnoses that inclure Parkinson's disease Resident # 44's mosset), a 30-Day asses (assessment referer Resident # 44 as so interview for mental - 15, seven - being sfor making daily decimental for making daily decimental and the periodic amount of red blood inserted into the peg closing. Resident will 96.6 (temperature), 5 (respiration), 143/90	e in which the body cannot to of sugar in the blood. This ained from the website: gov/medlineplus/ency/article/dialed to evidence that all tion and information was iving provider for a after on 04/16/19 for Resident dimitted to the facility on mission on 05/03/19 with ded but were not limited to (1), and anemia (2). It recent MDS (minimum data asment with an ARD ace date) of 06/10/19, coded oring a seven on the brief status (BIMS) of a score of 0 everely impaired of cognition sions. Ses Notes, dated 04/16/19 for mented in part, "20:43 (8:43 (8:00 p.m.), resident feeding alloon was still intact small noted. Foley cath (catheter) opening to prevent from thout distress, vital signs	F 62	22		8-29-19	
1 :	saturation) on room a	air. MD (medical doctor) was sfer to the hospital received,					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495283	B. WING			07	C /18/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-IMPERIAL		STREET ADDRESS 1719 BELLEVUE RICHMOND, VA			71012010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X EACH C	IDER'S PLAN OF CORRECTIO ORRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 622	R/P (responsible padiagnosis and the FResident sent to (Nambulance." Review of the clinic (electronic health reto evidence the require provided to the recent of the exident # 44's transfer (19). On 7/17/19 at 1:32 conducted with OSI regarding hospitaliz they send anything transfer, OSM #3 stombudsman, we had fax copy. Nurses have transferring to acute (administrative staff administrator, for doinformation was sent regarding Resident on 04/16/19. O7/18/19 at 11:50 a. not have the check can evidence what we started education prompleted before suprior." On 07/18/19 at appr (administrator, and Aministrator.	arty) was oriented to the dospital resident will go to. ame of Hospital) via (by) al record and the EHR ecord) for Resident # 44 failed uired documentation was eiving facility at the time of asfer to the hospital on p.m., an interview was who (other staff member) #3, ation process. When asked if to the receiving provider upon ated, "We send a fax to the eve a book where we keep a ave a folder-checklist when e care." The est was made to ASM member) #1, the poumentation that required at to the receiving provider # 44's transfer to the hospital m., ASM #1 stated, "We do lists, so there is no way you went to the hospital. We ior to survey but not urvey, we had identified this oximately 5:00 p.m., ASM	F 6	22			8-29-19	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495283	B. WING			0.	C 7/18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	<u> </u>	710/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	above findings. No further information References: (1) A type of movem information was obtaintys://www.nlm.nih.isease.html. (2) Low iron. This into the website: https://www.nlm.nih.isease.html. 7. The facility staff for required documental provided to the receifacility-initiated transifus. Resident # 59 was a 04/07/2017 with a rewith diagnoses that if to chronic obstructive malignant neoplasm unspecified bronchus disorder (3). Reside (minimum data set), an ARD (assessmen coded Resident # 59 assessment for men of 0 - 15, 15- being codaily decisions. The nurse's "Progress for Resident # 59 doc was sent to the hospical information of the progress of the sident # 59 doc was sent to the hospical information.	con was provided prior to exit. Ident disorder. This ained from the website: gov/medlineplus/parkinsonsdi Iformation was obtained from gov/medlineplus/anemia.html ailed to evidence that all tion and information was eving provider for a fer on 4/14/2019 for resident Idmitted to the facility on admission on 04/26/2019 included but were not limited to pulmonary disease (1), of unspecified part of sor lung (2) and anxiety int # 59's most recent MDS a quarterly assessment with the reference date) of 06/18/19, as scoring a 15 on the staff tal status (BIMS) of a score ognitively intact for making is Notes," dated 04/14/2019 cumented i part the resident	F6	622			8-29-19

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495283	B. WING			07	C /18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV		-	STREET ADDRESS, CITY, STATE, ZIP 1719 BELLEVUE AVENUE RICHMOND, VA 23227	CODE	1 07.	710/2019
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
	The nurse's "Progr for Resident # 59 d Resident admitted (intensive care unit Review of the clinic (electronic health re to evidence that all information was profor a facility-initiated Resident #59. On 07/16/19 at 2:36 conducted with Resabout recent hospit "I was in the hospit had too much CO2 I have COPD (chroid disease)." On 7/17/19 at 1:32 conducted with OSI regarding the hospit asked if they send a provider upon trans a fax to the ombuds we keep a fax copy folder-checklist when Con 07/17/19, a required (administrative staff administrator, for doinformation was sent regarding Resident on 4/14/19. 07/18/19 at 11:50 a. administrator, stated	less Notes," dated 04/14/2019 locumented, "13:07 (1:07 p.m.) to [name of hospital] in ICU of for acute respiratory failure." cal record and the EHR ecord) for Resident # 59 failed required documentation and evided to the receiving provider distransfer on 4/14/2019 for transfer	F 6	22			8-29-19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l''	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	495283	B. WING_	·	07	C		
PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		//18/2019		
		1	1719 BELLEVUE AVENUE				
CARE HEALTH SERV	ICES-IMPERIAL	İ	RICHMOND, VA 23227				
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE		
Continued From pa	ge 57	F 62	2		8-29-19		
survey but it was no	ot completed before survey,						
(administrator) and	ASM # 2 (the administrative	ı.X					
No further informati	on was provided prior to exit.						
References:							
(COPD) Disease that makes lead to shortness of obtained from the w	it difficult to breath that can breath. This information was rebsite:						
The term "malignan- cancerous cells that other sites in the bo- nearby (locally) and cells tend to have fa DO NOT die normal genetic makeup. Maresistant to treatmen detectable traces of destroyed. This in the website: https://medlineplus.go 3. anxiety Fear. This informati website:	cy" refers to the presence of have the ability to spread to dy (metastasize) or to invade destroy tissues. Malignant lest, uncontrolled growth and ly due to changes in their alignant cells that are not may return after all them have been removed or aformation was obtained from gov/ency/article/002253.htm.						
	PROVIDER OR SUPPLIER CARE HEALTH SERVI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa went to the hospital survey but it was no we had identified th On 07/18/19 at app (administrator) and director of nursing) findings. No further informati References: 1. Chronic obstructi (COPD) Disease that makes lead to shortness of obtained from the w https://www.nlm.nih 2. Malignant neopla The term "malignan cancerous cells that other sites in the bo nearby (locally) and cells tend to have fa DO NOT die normal genetic makeup. M resistant to treatmen detectable traces of destroyed. This in the website: https://medlineplus.g 3. anxiety Fear. This informati website:	PROVIDER OR SUPPLIER CARE HEALTH SERVICES-IMPERIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 57 went to the hospital. We started education prior to survey but it was not completed before survey, we had identified this prior." On 07/18/19 at approximately 4:40 p.m., ASM # 1 (administrator) and ASM # 2 (the administrative director of nursing) were made aware of the findings. No further information was provided prior to exit. References: 1. Chronic obstructive pulmonary disease (COPD) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2. Malignant neoplasm The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm. 3. anxiety Fear. This information was obtained from the	PROVIDER OR SUPPLIER CARE HEALTH SERVICES-IMPERIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 57 went to the hospital. We started education prior to survey but it was not completed before survey, we had identified this prior." On 07/18/19 at approximately 4:40 p.m., ASM # 1 (administrator) and ASM # 2 (the administrative director of nursing) were made aware of the findings. No further information was provided prior to exit. References: 1. Chronic obstructive pulmonary disease (COPD) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2. Malignant neoplasm The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm. 3. anxiety Fear. This information was obtained from the website:	PROVIDER OR SUPPLIER CARE HEALTH SERVICES-IMPERIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 57 went to the hospital. We started education prior to survey but it was not completed before survey, we had identified this prior." On 07/18/19 at approximately 4:40 p.m., ASM # 1 (administrator) and ASM # 2 (the administrative director of nursing) were made aware of the findings. No further information was provided prior to exit. References: 1. Chronic obstructive pulmonary disease (COPD) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2. Malignant neoplasm The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells that are resistant to thave fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or the streatment may return after all detectable traces of them have been removed or the website: https://medlineplus.gov/ency/article/002253.htm. 3. anxiety Fear. This information was obtained from the website:	PROVIDER OR SUPPLIER CARE HEALTH SERVICES-IMPERIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) WISTER E PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 57 went to the hospital. We started education prior to survey but it was not completed before survey, we had identified this prior.' On 07/18/19 at approximately 4:40 p.m., ASM # 1 (administrator) and ASM # 2 (the administrative director of nursing) were made aware of the findings. No further information was provided prior to exit. References: 1. Chronic obstructive pulmonary disease (COPD) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nil.gov/medlineplus/copd.html. 2. Malignant neoplasm The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm. 3. anxiety FREQUENTIAL TATION TO THE APPROPRIATE AREA TO THE APPROPRIATE		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DESICIENCIES.

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED					
		495283	B. WING			07	C //18/2010	
	PROVIDER OR SUPPLIER	ICES-IMPERIAL	STREET ADDRESS, CITY, STATE, ZIP C 1719 BELLEVUE AVENUE RICHMOND, VA 23227			07/18/2019 CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD IE APPROPE	BE	(X5) COMPLETION DATE	
F 622	Continued From pa	ge 58	F 62	22	-	_	8-29-19	
	required documents provided to the rece	sfer on 5/4/19, 5/26/19 and						
	11/01/2016 with a re Resident #70's diag limited to type 2 dia (2), and essential hy #70's most recent N quarterly assessme reference date) of 6 as scoring a 14 on t mental status (BIMS	idmitted to the facility on eadmission on 05/27/2019. Inoses included but were not betes mellitus (1), glaucoma ypertension (3). Resident MDS (minimum data set), a nt with an ARD (assessment /30/19, coded Resident # 70 he staff assessment for 6) of a score of 0 - 15, 13-15 act for making daily decisions.						
	for Resident # 70 do Resident xray result	ess Notes," dated 05/04/2019 ocumented, "18:25 (6:25 p.m.) is shows right femoral neck to be transferred to [name of						
	for Resident # 70 do Resident was in the wheelchair, CNA (ce to feed him and the unresponsive. This and to assess reside to deep sternum rub was thread and wea a.m.). Upon placing grunt was audible. F	ss Notes," dated 05/26/2019 ocumented, "09:20 (9:20 a.m., laurel day room in his ertified nurse's assistant) went resident was found to be writer was called into the hall ent. Resident unresponsive not breathing and his pulse k. 911 called at 0910 (9:10 resident back in bed, a short Resident placed on non (liters per minute). Upon						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DESICIENCIES (VXI) PROVIDED OF DESICIENCIES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED			
		495283	B. WING			07	C / 18/2019
	PROVIDER OR SUPPLIER	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZII 1719 BELLEVUE AVENUE RICHMOND, VA 23227	P CODE	<u>, 07.</u>	110/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
	EMS (emergency management became resident became resident dand stated (medical doctor) not instructed the RN (resident out to the harty) notified. Papagreement sent with The nurse's "Progrefor Resident # 70 downter called to the nurse's assistant) proconcerned about resusual Writer noticed right knee outer aspendicated for pain a effective. MD (mediaware and Writer wathe ER (emergency resident was transfestretcher." Review of the clinical (electronic health resident was profor a facility-initiated and 6/18/19 for resident was transfer on 7/17/19 at 1:32 pronducted with OSM regarding hospitalizathey send anything to transfer, OSM #3 stambudsman, we have	nedical services) arriving, sponsive and alert and "I was just taking a nap." MD tified at 0920 (9:20 a.m.) and egistered nurse) to send the tospital. RP (responsible erwork and bedhold a resident." The session of the conditio	F 62				8-29-19

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-IMPERIAL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 622 Continued From page 60 On 07/17/19 a request was made to ASM (administrator, for documentation that required information was sent to the receiving provider regarding Resident # 70's transfer to the hospital on 5/4/19, 5/26/19 and 6/18/19. 07/18/19 at 11:50 a.m., ASM #1 stated, "We do not have the check lists, so there is no way you can evidence what went to the hospital. We started education prior to survey but it was not completed before survey, we had identified this prior." On 07/18/19 at approximately 4:40 p.m., ASM # 1	AND PLAN OF CORRECTION I IDENTIFICATION NUMBER		ING			TE SURVEY MPLETED		
MANORCARE HEALTH SERVICES-IMPERIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPR			495283	B. WING			07	C //18/2010
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 622 Continued From page 60 On 07/17/19 a request was made to ASM (administrative staff member) #1, the administrator, for documentation that required information was sent to the receiving provider regarding Resident # 70's transfer to the hospital on 5/4/19, 5/26/19 and 6/18/19. 07/18/19 at 11:50 a.m., ASM #1 stated, "We do not have the check lists, so there is no way you can evidence what went to the hospital. We started education prior to survey but it was not completed before survey, we had identified this prior." PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFER			CES-IMPERIAL		1719 BELLEVUE AVENUE	, ZIP CODE	<u> </u>	710/2019
On 07/17/19 a request was made to ASM (administrative staff member) #1, the administrator, for documentation that required information was sent to the receiving provider regarding Resident # 70's transfer to the hospital on 5/4/19, 5/26/19 and 6/18/19. 07/18/19 at 11:50 a.m., ASM #1 stated, "We do not have the check lists, so there is no way you can evidence what went to the hospital. We started education prior to survey but it was not completed before survey, we had identified this prior." On 07/18/19 at approximately 4:40 p.m., ASM # 1	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD O THE APPROPI) BE	(X5) COMPLETION DATE
(administrator) and ASM # 2 (the administrative director of nursing) were made aware of the findings. No further information was provided prior to exit. References: 1. diabetes mellitus A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 2. glaucoma A group of diseases that can damage the eye's optic nerve. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/glaucoma.ht ml. 3. hypertension High blood pressure. This information was		On 07/17/19 a requi (administrative staff administrator, for do information was ser regarding Resident on 5/4/19, 5/26/19 at 07/18/19 at 11:50 at not have the check can evidence what is started education prompleted before started education prompl	est was made to ASM member) #1, the ocumentation that required at to the receiving provider #70's transfer to the hospital and 6/18/19. m., ASM #1 stated, "We do lists, so there is no way you went to the hospital. We for to survey but it was not urvey, we had identified this examinately 4:40 p.m., ASM #1 ASM #2 (the administrative were made aware of the con was provided prior to exit. which the body cannot of sugar in the blood. This ained from the website: gov/medlineplus/ency/article/ that can damage the eye's formation was obtained from gov/medlineplus/glaucoma.ht	F 62	22			8-29-19

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495283	B. WING _			C /18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVE	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 077	110/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	essure.html.	rebsite: .gov/medlineplus/highbloodpr ts Before Transfer/Discharge	F 62		12	8-29-19
SS=E	§483.15(c)(3) Notice Before a facility tran resident, the facility (i) Notify the resident representative(s) of the reasons for the language and mann facility must send a representative of the Long-Term Care On (ii) Record the reasons discharge in the resident and (iii) Include in the no paragraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specific (c)(8) of this section, discharge required unade by the facility aresident is transferred (ii) Notice must be metalogered under this section; (B) The health of ind be endangered, under this section;	e before transfer. sfers or discharges a must- it and the resident's the transfer or discharge and move in writing and in a er they understand. The copy of the notice to a e Office of the State inbudsman. ons for the transfer or ident's medical record in fagraph (c)(2) of this section; tice the items described in his section. g of the notice. ed in paragraphs (c)(4)(ii) and the notice of transfer or inder this section must be at least 30 days before the id or discharged. inade as soon as practicable		The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated It is the intended practice of this facility to provide written notification of a transfer/discharge to the resident, representative, and the Ombudsman. 1. Upon notification from surveyor on 7-18-19, facility Administrator educated administrative staff regarding written notification to the responsible party related to all facility initiated transfers to hospital.		2 2 1 1 7

	D PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495283	B. WING		,	C 07/18/2019
	(EACH DEFICIENCY	CES-IMPERIAL TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	CTION OULD BE	(X5) COMPLETION DATE
F 623	allow a more immedunder paragraph (c) (D) An immediate trrequired by the residunder paragraph (c) (E) A resident has notice specified in paragraph (c) (E) A resident has notice specified in paragraph (c) (ii) The reason for transferred or dischastilliam (iii) The location to varansferred or dischastilliam (v) A statement of the including the name, and telephone number completing the form hearing request; (v) The name, addretelephone number of Long-Term Care Om (vi) For nursing faciliand developmental disabilities, the mailiatelephone number of the protection and acdevelopmental disabilities of the Developmental disabilities and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilidisorder or related dismail address and terminate in the protection of the disorder or related dismail address and terminate in the protection of the disorder or related dismail address and terminate in the protection of the disorder or related disparagraphs.	diate transfer or discharge, (1)(i)(B) of this section; ansfer or discharge is dent's urgent medical needs, (1)(i)(A) of this section; or ot resided in the facility for 30 ents of the notice. The written aragraph (c)(3) of this section owing: ansfer or discharge; e of transfer or discharge; which the resident is arged; ne resident's appeal rights, address (mailing and email), ber of the entity which sts; and information on how form and assistance in and submitting the appeal ess (mailing and email) and if the Office of the State abudsman; ty residents with intellectual disabilities or related and email address and if the agency responsible for dvocacy of individuals with dilities established under Part and Disabilities Assistance of 2000 (Pub. L. 106-402,	F	2. Residents that the facility initiat transfer to the hospital have the potential to be affected. 3. Director of Nursing and/or design to re-educate Licensed Nurses and Social Services on the Acute Called Transfer Documentation Check in order to make sure that the provide written notification to resident's responsible party upon facility initiated transfer to a hospital. 4. Director of Nursing and/or design will audit written notification to residents responsible party for a acute care transfers daily x 5 days and then 3 days a week x 3 week and then monthly x 2 months. It results of the random audits will reported to the QAA Committee review and follow up recommendations as indicated 5. The facility alleged date of compliance is August 29, 2015	nee ind re ist, y he na nee the ony ys ks he be for	8-29-19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING	i		ı	C /18/2019
	PROVIDER OR SUPPLIER	CES-IMPERIAL		1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	<u> </u>	/16/2019
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	advocacy of individue stablished under the for Mentally III Individuals and the information in effecting the transfermust update the recast practicable once becomes available. §483.15(c)(8) Notice In the case of facility the administrator of written notification provide to the State Survey of State Long-Term Cathe facility, and the result as the plan for the relocation of the result as the plan for the Requiremental the survey and the review, it was determined to the survey sample, if \$483.70(l). This REQUIREMENT by: Based on staff intermediem, it was determined to the result as the plan for the review, it was determined to the result and the survey sample, if \$484, \$444, \$489, and \$488. The findings include 1. The facility staff facility sta	uals with a mental disorder ne Protection and Advocacy iduals Act. ges to the notice. the notice changes prior to er or discharge, the facility sipients of the notice as soon the updated information e in advance of facility closure or closure, the individual who is the facility must provide rior to the impending closure Agency, the Office of the are Ombudsman, residents of resident representatives, as the transfer and adequate idents, as required at § IT is not met as evidenced view and clinical record mined the facility staff failed to cation to the resident and/or ive for eight of 54 residents in Residents #40, #21, #7, #24, 70. : alled to provide written sident and/or resident esident #40's facility initiated	F	323			8-29-19

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		TE SURVEY MPLETED
		495283	B. WING	•			C
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	07	/18/2019
MANOR	CARE HEALTH SERV	CES-IMPERIAL		17	719 BELLEVUE AVENUE ICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROP	BE	(X5) COMPLETION DATE
	with diagnoses that to: stroke, demential to: stroke, demential The most recent MI assessment, a quarassessment references ident as scoring interview for mental resident was severe cognitive decisions. A physician order da "Send to (name of htube) replacement." The nurse's note da documented "Went peg tube dressing a inflated laying (sic) to (medical doctor) not (name of hospital) for placed to RP (responsive to RP (responsive to RP). An interview was computed in the reason for the trawere advised recent we haven't been doing were notified of this, that we need to send resident or the responsible to the policy of discharge requirements.	included but were not limited a, and high blood pressure. OS (minimum data set) terly assessment, with an ace date of 6/4/19, coded the a "3" on the BIMS (brief status) score, indicating the ely impaired to make daily ated, 4/25/19, documented, aspital) for peg tube (feeding ted, 4/25/19 at 2:38 a.m. to resident room to change and found peg tube fully beside him in the bedMD affied received order to send to be or peg tube replacement. Call ansible party) left message on ted to (name of hospital)." Inducted on 7/17/19 at 1:32 member (OSM) #3 and OSM as at the facility. When asked dent and/or the resident ting of a hospital transfer and ansfer, OSM #3 stated, "We by that it should be done, but any it." When asked when they OSM #3 stated, "Last week it written notification to the	Fe	523			8-29-19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING			07	C /18/2019	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	s	TREET ADDRESS, CITY, STATE, ZIP CODE	07	/16/2019	
MANOD	PADE HEALTH OFDW	OFO MADEDIAL		1	719 BELLEVUE AVENUE			
WANOR	CARE HEALTH SERVI	CES-IMPERIAL	ĺ	R	RICHMOND, 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 APPROPR DEFICIENCY)	8E	(X5) COMPLETION DATE	
F 623	Continued From paga.m.	i	F6	23			8-29-19	
	(ASM) #1, and ASM director of nursing,	administrative staff member #2, the administrative and ASM #3, the quality nt, were made aware of the /18/19 at 4:25 p.m.						
	No further information	on was obtained prior to exit.						
		ary of Medical Terms for the r, 5th edition, Rothenberg and					:	
:	notification to the re-	ailed to provide written sident and/or resident facility initiated transfer of hospital on 3/30/19.						
	3/9/18 with a recent diagnoses that includiabetes, depression The most recent MD assessment, a Medi with an assessment coded the resident a (brief interview for m	dmitted to the facility on readmission on 4/4/19, with ded but were not limited to: n, and high blood pressure. S (minimum data set) care 30 day assessment, reference date of 4/30/19, s scoring a "15" on the BIMS lental status) score, indicating making daily cognitive						
	documented in part, very lethargic, alert a did not eat dinner, re Vital signs 100.8 (ter 20 (respirations) 141	ed, 3/30/19 at 11:06 p.m. "Resident was found to be and not responding to verbal, fuse to take her medications. inperature), 91 (heart rate), /73 (blood pressure), with of 85% on room air. MD						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		ATE SURVEY OMPLETED	
		495283	B. WING			C 7/18/2019
	PROVIDER OR SUPPLIER	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		7710/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	received. Resident a were oriented to the facility, resident is g was called and reside of hospital) at 2300 document sent with The physician order documented, "Send hospital) for evaluating An interview was cop.m. with other staff #4, the social worke if they notify the resire representative in writhe reason for the trawere advised recent we haven't been doing were notified of this, that we need to send resident or the responsible to the respon	s notified order to transfer out and R/P (responsible party) diagnosis and the acute care oing to. Emergency response dent was transported to (name (11:00 p.m.) Bed hold the patient." dated, 3/30/19 at 11:23 p.m. the resident to (name of ion." anducted on 7/17/19 at 1:32 member (OSM) #3 and OSM rs at the facility. When asked dent and/or the resident ting of a hospital transfer and ansfer, OSM #3 stated, "We ly that it should be done, but ng it." When asked when they OSM #3 stated, "Last week di written notification to the onsible party." dministrative staff member #2, the administrative staff member #2, the administrative ind ASM #3, the quality it, were made aware of the 18/19 at 4:25 p.m. In was obtained prior to exit. itled to provide written sident and/or resident recility initiated transfer of	F 6	23		8-29-19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD	TIPLE CONSTRUCTION			TE SURVEY MPLETED
		495283	B. WING				C /18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP 1719 BELLEVUE AVENUE RICHMOND, VA 23227	CODE	07	110/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	l	N SHOULD E APPROPR	BE	(X5) COMPLETION DATE
	10/11/18 with diagninot limited to: multip disease in which ne spinal cord lose the disorder, morbid ob depression. The modata set) assessment coded the resident a (brief interview for mathe resident was cap cognitive decisions. The nurse's note dadocumented, "Husb concerned for patier half due to nausea a her medications. Panurse that she is har to her shoulders." TI 5/19/19 at 3:24 p.m. doctor) notified on cadirected for patient to go to (initial ambulance company Patient went via amb ER (emergency roor An interview was corp.m. with other staff #4, the social worker if they notify the residere resentative in writher eason for the trawer advised recent we haven't been doir were notified of this,	oses that included but were ble sclerosis (a progressive rive fibers of the brain and ir myelin cover) (1), anxiety esity, diabetes, and lest recent MDS (minimum int, a quarterly assessment, a reference date of 4/18/19, as scoring a "15" on the BIMS inental status) score, indicating bable of making daily ted, 5/19/19 at 2:34 p.m. and came to nurse's station inthasn't eaten past day and and vomiting, and is refusing tient did relay to the other wing mid sternal pain radiating ine nurse's note dated, documented, "(Name of all by RN (registered nurse), or go to ER. Husband wanting hals of hospital, (Name of all by RN (registered nurse), or go to ER. Husband wanting hals of hospital, (Name of all of the complete in the facility. When asked dent and/or the resident thing of a hospital transfer and ansfer, OSM #3 stated, "We by that it should be done, but hig it." When asked when they OSM #3 stated, "Last week I written notification to the	F 6	23			8-29-19

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	TIPLE CONSTRUCTION ING		ATE SURVEY OMPLETED	
		495283	B. WING			C 7/18/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		7710/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
	The administrator, (ASM) #1, and ASM director of nursing, assurance consulta above concern on a surance consulta above concern on a surance consulta above concern on a surance consulta above concern on a surance concern	administrative staff member #42, the administrative and ASM #3, the quality ant, were made aware of the 7/18/19 at 4:25 p.m. on was obtained prior to exit. er, 5th edition, Rothenberg and 0. failed to provide Resident #24's representative written lity-initiated transfer on	F6	23		8-29-19
		ss Notes," dated 05/10/2019 ocumented,"11:36 (11:36				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495283	B. WING			07	C /18/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, 1719 BELLEVUE AVENU RICHMOND, VA 2322	UE	1 07	/16/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPM EFICIENCY)	BE	(X5) COMPLETION DATE	
	a.m.) Informed by s responsive when et 11:10 am (a.m.) b/p (one-hundred-nine O2 (oxygen) sat (sat 41 (four liters) saevaluated resident (emergency room) (responsible party) changed in condition Hospital) for evaluated Review of the clinic (electronic health reto evidence docume and/or Resident #2 provided written not transfer to the hospitalization proceptovide written notif resident and/or resi	staff resident was non intered room approximately (blood pressure 109/64 over sixty-four), p (pulse) 85, aturation) on room air 80%, O2 TUP TO 97%. NP in building instruction to send to erfor evaluation. RP was made aware of resident in and sending to (Name of tion." all record and the EHR ecord) for Resident # 24 failed entation that Resident # 24 4's representative were iffication of Resident # 24's ital on 03/29/19 and 05/10/19. b.m., an interview was of (other staff member) # 3, rvices, regarding ess. When asked if they ication of transfer to the dent's representative OSM #3 fax to the ombudsman, we we keep a fax copy. We have anything in writing; we were ve been done but are not ted when they were advised doing it, OSM# 3 stated, "" oximately 5:00 p.m., ASM	F	23			8-29-19	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	FIPLE CONSTRUCTION NG		E SURVEY MPLETED
		405000	D MING		- 1	С
		495283	B. WING		07/	18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	References: (1) A stroke. When brain stops. A stroke attack." If blood flow few seconds, the broxygen. Brain cells damage. This inform website: https://medlineplus.(2) A chronic diseas regulate the amount information was obth https://www.nlm.nih.001214.htm. 5. The facility staff frontification of a facil 06/26/19. Resident # 78 was a 11/29/17 and a read diagnoses that incluing hypertension (1), an Resident # 78's most	blood flow to a part of the e is sometimes called a "brain w is cut off for longer than a ain cannot get nutrients and can die, causing lasting nation was obtained from the gov/ency/article/000726.htm. e in which the body cannot to f sugar in the blood. This ained from the website: gov/medlineplus/ency/article/ failed to provide Resident # 18's representative written ity-initiated transfer on admitted to the facility on mission on 06/30/19 with ded but were not limited to diabetes mellitus (2). Set recent MDS (minimum data)	F 62			8-29-19
	Resident # 78 as sci interview for mental	oring a three on the brief status (BIMS) of a score of 0 everely impaired of cognition				
İ	for Resident # 78 do Resident alert and v	ss Notes," dated 06/26/2019 cumented, "17:19 (5:19 p.m.) erbal, denies pain, VS (vital ature), 108 (heart rate), 14				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED			
		495283	B. WING	i		07	C /18/2019
	PROVIDER OR SUPPLIER	<u> </u>	I	17	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE ICHMOND, VA 23227	1 07	710/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	(respiration), 128/6 hundred twenty-eig (oxygen saturation) MD (medical doctor of Hospital) for high dehydration. Resid (at) 17:10 (5:10) Review of the clinic (electronic health reto evidence docume and/or Resident # 7 provided written not transfer to the hosp On 7/17/19 at 1:32 conducted with OSI director of social se hospitalization procprovide written notif resident and/or resistated, "We send a have a book where not been providing advised it should had oing it." When ask that they should be "Maybe a week ago On 07/18/19 at application of nursing, above findings. No further information.	8 (blood pressure) (one ht over sixty-eight), 94% RA (room air). Resident after r) approval was sent to (Name a sodium level and lent went via (by) ambulance p.m.)." al record and the EHR record) for Resident # 78 failed rentation that Resident # 78 res	F	623			8-29-19

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		495283	B. WING			C 0 7/18/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1719 BELLEVUE AVENUE RICHMOND, VA 23227		07710/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 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)	OULD BE	(X5) COMPLETION DATE
F 623	essure.html. (2) A chronic disease regulate the amoun information was obth https://www.nlm.nih 001214.htm. 6. The facility staff 44 and Resident # 4 notification of a faci 04/16/19. Resident # 44 was a 02/17/14 and a read diagnoses that inclue Parkinson's disease Resident # 44's moset), a 30-Day asset (assessment references Resident # 44 as so interview for mental - 15, seven - being sfor making daily decorate out, the ballocal amount of red blood inserted into the pegclosing. Resident w 96.6 (temperature), (respiration), 143/90 hundred forty-three saturation) on room	rebsite: .gov/medlineplus/highbloodpr se in which the body cannot t of sugar in the blood. This ained from the website: .gov/medlineplus/ency/article/ failed to provide Resident # 44's representative written lity-initiated transfer on admitted to the facility on dimission on 05/03/19 with ded but were not limited to e (1), and anemia (2). Ist recent MDS (minimum data assment with an ARD nce date) of 06/10/19, coded oring a seven on the brief status (BIMS) of a score of 0 severely impaired of cognition disions. ss Notes," dated 04/16/19 for mented, "20:43 (8:43 p.m.) At m.), resident feeding tube on was still intact small inoted. Foley cath (catheter) g opening to prevent from ithout distress, vital signs	F 62	23		8-59-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING				C /18/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI		J	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 07	110/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 623	R/P (responsible padiagnosis and the Fresident sent to (Nambulance." Review of the clinical (electronic health reto evidence docume and/or Resident # 4 provided written not transfer to the hospitalization proceprovide written notificated, "We send a have a book where not been providing a advised it should had oing it." When ask that they should be "Maybe a week ago." On 07/18/19 at appreciation (administrative staff adminis	arty) was oriented to the lospital resident will go to. ame of Hospital) via (by) all record and the EHR cord) for Resident # 44 failed entation that Resident # 44 d's representative were ification of Resident # 44's ital on 04/16/19. c.m., an interview was of (other staff member) # 3, rvices, regarding less. When asked if they ication of transfer to the dent's representative OSM #3 fax to the ombudsman, we we keep a fax copy. We have anything in writing; we were ve been done but are not led when they were advised doing it, OSM# 3 stated, coximately 5:00 p.m., ASM member) #1, the SM #2, the administrative were made aware of the on was provided prior to exit.	F 6	23			8-29-19	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495283	B. WING		07	//18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP COD 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 PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	(2) Low iron. This in the website: https://www.nlm.nih 7. The facility staff 59 and Resident # 59 and Resident # 104/14/19 for Resident # 104/07/2017 with a rwith diagnoses that to chronic obstructionalignant neoplasm unspecified bronched disorder (3). Resident malignant neoplasm unspecified bronched isorder (3). Resident malignant neoplasm unspecified bronched isorder (3). Resident malignant neoplasm unspecified bronched isorder (3). Resident malignant neoplasm unspecified bronched isorder (3). Resident # 50 assessment for med for 15, 15- being daily decisions. The nurse's "Progref for Resident # 59 do resident complained [sic] states that he for resident currently or cannula and sats (swas given prn (as not treatment) and inhale effective resident als MD (medical doctor ordered to be transfevaluation resident in person) called and resident in the person called and reside	nformation was obtained from a gov/medlineplus/anemia.html failed to provide Resident # 59's representative written lity-initiated transfer on a material factor of the facility on eadmission on 04/26/2019 included but were not limited by pulmonary disease (1), and of unspecified part of the facility on eadmission on 04/26/2019 included but were not limited by pulmonary disease (1), and of unspecified part of the facility on eadmission on 04/26/2019 included but were not limited by pulmonary disease (1), and for unspecified part of the facility of unspecified part of unspecified p	F6	23		8-24-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING			07	C /18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		17	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE CHMOND, VA 23227	1 07.	710/2019
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Continued From pa The nurse's "Progre for Resident # 59 do	ge 75 ess Notes," dated 04/14/2019 ocumented, "13:07 (1:07 p.m.) i	F 6	23			8-29-19
	Resident admitted to (intensive care unit) Review of the clinical (electronic health re to evidence documents)	o [name of hospital] in ICU for acute respiratory failure." al record and the EHR cord) for Resident # 59 failed entation that Resident # 59					
	and/or Resident # 59's representative were provided written notification of Resident # 59's transfer to the hospital on 04/14/2019. On 7/17/19 at 1:32 p.m., an interview was conducted with OSM (other staff member) #3, regarding hospitalization process. When asked if they provide written notification of transfer to the						
	stated, "We send a have a book where not been providing a advised it should ha doing it." When ask	dent's representative OSM #3 fax to the ombudsman, we we keep a fax copy. We have anything in writing, we were ve been done but are not ed when they were advised doing it, OSM#3 stated,					
		oximately 4:40 p.m., ASM # 1 ASM # 2 (director of nursing) the findings.					į
	No further information	n was provided prior to exit.				İ	
Ī	References:					į	
	Disease that makes lead to shortness of obtained from the we	e pulmonary disease (COPD) it difficult to breath that can breath. This information was ebsite:					

	OF CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
		495283	B. WING			07	C 7 /18/2019
	PROVIDER OR SUPPLIER	CES-IMPERIAL		171	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE CHMOND, VA 23227	1 07	710/2019
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	2. Malignant neopla The term "malignan cancerous cells that other sites in the bonearby (locally) and cells tend to have fa DO NOT die norma genetic makeup. Maresistant to treatmed detectable traces of destroyed. This in the website: https://medlineplus.com/medlineplus.	ism icy" refers to the presence of it have the ability to spread to ody (metastasize) or to invade destroy tissues. Malignant ast, uncontrolled growth and lly due to changes in their dalignant cells that are int may return after all them have been removed or information was obtained from gov/ency/article/002253.htm. ion was obtained from the gov/medlineplus/anxiety.html failed to evidence that all ation and information was iving provider for a sier on 5/4/19, 5/26/19 and	F6	23			8-58-14

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495283	B. WING_			C 7/18/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODI 1719 BELLEVUE AVENUE RICHMOND, VA 23227		7710/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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)	OULD BE	(X5) COMPLETION DATE	
	The nurse's "Progrefor Resident # 70 do Resident xray result fracture. Resident thospital]." The nurse's "Progrefor Resident # 70 do p.m.), Resident retule is alert and verbaroutine pain medica Resident has a follo [orthopedic clinic na [clinic phone number (blood pressure) 64, 20, (respirations) 02, 98%." The nurse's "Progrefor Resident # 70 do Resident was in the wheelchair, CNA (ceto feed him and the unresponsive MI 0920 (9:20 a.m.) and (registered nurse) to hospital. RP (responsible in the improvement in the i	ess Notes," dated 05/04/2019 ocumented, "18:25 (6:25 p.m.) is shows right femoral neck to be transferred to [name of the search	F 62	23		8-29-19	

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

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	DING		COMPLETED
		495283	B. WING	i		C 07/18/2019
	PROVIDER OR SUPPLIER	ICES-IMPERIAL		STREET ADDRESS, CITY, STATE, 1719 BELLEVUE AVENUE RICHMOND, VA 23227	, ZIP CODE	07/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	CTION SHOULD O THE APPROPR	BE COMPLETION
	the ER (emergency resident was transfirstretcher." Review of the clinic (electronic health reto evidence docume and/or Resident # 7 provided written not transfer to the hosp 6/18/19. On 7/17/19 at 1:32 conducted with OSI regarding hospitaliz they provide written resident and/or resistated, "We send a have a book where not been providing advised it should had oing it." When ask that they should be "Maybe a week ago On 07/18/19 at appreciate they aware of the ware made aware of	vas ordered to send resident to room) for further evaluation erred to the hospital via all record and the EHR ecord) for Resident # 70 failed entation that Resident # 70 o's representative were diffication of Resident # 70's ital on 5/4/19, 5/26/19 and p.m., an interview was with the continuous of transfer to the dent's representative OSM #3 fax to the ombudsman, we we keep a fax copy. We have anything in writing; we were eve been done but are not seed when they were advised doing it, OSM#3 stated, "" roximately 4:40 p.m., ASM # 1 ASM # 2 (director of nursing)	Fé	523		8-29-19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	7	RIPLE CONSTRUCTION NG		COM	E SURVEY MPLETED
		495283	B. WING		·	ı	C 18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		STREET ADDRESS, CIT 1719 BELLEVUE AVE RICHMOND, VA 23	NUE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	optic nerve. This in the website:	ge 79 that can damage the eye's formation was obtained from .gov/medlineplus/glaucoma.ht	F6	23			8-29-19
F.044	obtained from the w https://www.nlm.nih essure.html.	.gov/medlineplus/highbloodpr	F.0		F – 641		8-29-19
	resident's status. This REQUIREMENty: Based on staff interestant clinical record refacility staff failed to (minimum data set) residents in the surv		F 6	The statem correction a do not cons the alleged remain in a and state in taken or will the folio constitutes compliant cited have a the dollar.	nents made on this plan of tre not an admission to and titute an agreement within deficiencies cited herein. To compliance with all federal regulations, the center has I take the actions set forth in the center's allegation of ce. All alleged deficiencies been or will be corrected by ate or dates indicated	n ,	
	Cognitive Patterns a the resident's quarte	eiled to complete Section C - accurately for Resident #61 on orly MDS (minimum data set) a assessment reference date		that the ass th 1. Resid	ended practice of the facility sessments accurately reflec- ne resident's status. dent #61 still resides in the cility. Resident #99 has	y t	

		I DENTIFICATION NUMBER.			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING				С
NAME OF	BROVIDED OF GUIDBLIED	493203	D. WING			07	/18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		171	REET ADDRESS, CITY, STATE, ZIP CODE		
				RIC	CHMOND, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	9/14/16, with diagnor not limited to: schize mental disorders che distortions of reality language, perceptio (1), and macular de degeneration, or agdegeneration [AMD] loss in Americans 6 destroys your sharp central vision to see tasks such as readil. The most recent ME assessment, a quarrassessment referent resident in Section E Vision, as usually uralways making hims Cognitive Patterns, and the resident was long-term memory diseverely impaired to decisions. An interview was concurse) #5, the MDS (licensed practical not 7/17/19 at 2:35 p.m. Section B of the MDS nurses cod asked if a resident is usually understood, Section C be completed, Section C be completed.	dmitted to the facility on oses that included but were ophrenia (Any of a group of aracterized by gross withdrawal of thought, on and emotional response) generation [Macular e-related macular lis a leading cause of vision of and older. A disease central vision. You need objects clearly and to do	F6	41	discharged. MDS staff were reeducated on 7-18-19 on accurate assessments upon notification of surveyor. 2. Residents that have minimum data set assessments have the potential to be affected. 3. Administrator and/designee to reeducate MDS staff, social services, and the Interdisciplinary Team (IDT) on ensuring that all residents are assessed timely and are coded correctly. 4. Administrator and/or designee will audit MDSs daily x 5 days, then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be August 29, 2019.		8-29-19

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		E CONSTRUCTION	COMPLETED		
		495283	B. WING			07	C / 18/2019	
	PROVIDER OR SUPPLIER	CES-IMPERIAL		1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	, 0.	710/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 641	Section C and woul information. On 7/17/19 at 3:41 returned and stated and Section C is not asked what resource the MDS assessment (resident assessment) The RAI manual do Should Brief Intervie Conducted? - Code be conducted because ometimes understrusing another method needed, one is avait conduct the intervie interview is conduct period of the Assessment.	ge 81 d get back with this p.m., RN #5 and LPN #2 I that Section B is accurate it coded accurately. When is the staff use to complete ints, RN #5 stated, "The RAI int instrument) manual." cumented in part, "C0100: is w for Mental Status be 1, yes: if the interview should use the resident is at least bod verbally, in writing, or od, and if an interpreter is lable. Coding Tips - Attempt to w with ALL residents. This ed during the look-back sment Reference Date (ARD) t upon item B0700, Make Self	Fé	341			8-79-19	
	administrator, ASM of nursing, and ASM	member (ASM) #1, the #2, the administrative director I #3, the quality assurance de aware of the above at 4:50 p.m.		,				
	(1) Barron's Dictiona Non-Medical Reade Chapman, page 522 2. The facility staff the Resident # 99's disconthe discharge MI	ary of Medical Terms for the r, 5th edition, Rothenberg and called to accurately code tharge statue to community DS (minimum data set) ARD (assessment reference		e e				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (XX) PROVIDED (SUPPLIED LED COLOR

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED			
		495283	B. WING			07	C /18/2019
	PROVIDER OR SUPPLIER	CES-IMPERIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227			07/10/2019	
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 641	Resident # 99 was 03/27/19 with diagn not limited to muscl and high blood president # 99's MD discharge assessm reference date) of 0 as "03 (three) - Acu "A2100 Discharge SThe facility's "Care 04/19/19 document discharged home w Assisted Living) with SW (social worker) Living) representative provided at the sat family's request.	admitted to the facility on oses that included but were e weakness, difficulty walking sure. S (minimum data set), a ent with an ARD (assessment 4/29/19, coded Resident # 99 te hospital" under "Section Status." Plan Progress Note" dated ed in part, "Resident will be ith spouse at (Name of Name of Home Health). spoke with (Name of Assisted of the edite	F6	41			8-29-19
	The facility's "Progradocumented in part, appx (approximately On 07/18/19 at apprinterview was condupractical nurse) # 2, asked if Resident # Anticipated" on the I 04/29/2019 was cook Resident # 99's progravices notes, LPN asked to describe the	ess Notes" dated 04/29/2019 "Discharged with husband at y) 0930 (9:30 a.m.) this shift." roximately 10:00 a.m., an acted with LPN (licensed MDS coordinator. When 99's "Discharge Return Not MDS assessment dated led correctly. After reviewing gress notes and the social # 2 stated, "No." When he process for coding the he correct discharge location					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING			1	C /18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 645 SS=E	discharge planning and daily meetings. On 07/18/19 at app (administrative staff administrator, and A were made aware of the No further information of the individuals with a mount of after January 1, 1 (i) Mental disorder a (i) of this section, unauthority has determindependent physical performed by a personal the level of services and (B) If the individual reservices, whether the specialized services (ii) Intellectual disability intellectual disability in the level of services (iii) Intellectual disability intellectual disability	e get the information from meetings, care plan meetings roximately 5:00 p.m., ASM member) #1, the ASM #2, director of nursing, of the above findings. on was provided prior to exit. for MD & ID (1)-(3) dission Screening for ental disorder and individuals ability. sing facility must not admit, on 989, any new residents with: as defined in paragraph (k)(3) aless the State mental health hined, based on an all and mental evaluation con or entity other than the authority, prior to admission, if the physical and mental evaluation for or entity other than the authority, prior to admission, if the physical and mental evaluation for or entity other than the authority, prior to admission, if the physical and mental evaluation for entity other than the authority, prior to admission, if the physical and mental evaluation for entity other than the authority, prior to admission, if the physical and mental evaluation are provided by a nursing facility; requires such level of the individual requires in the state or developmental disability	F6				8-29-19
	(A) That, because o	nined prior to admission- f the physical and mental vidual, the individual requires					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION		E SURVEY
		405000	B. WING			ı	С
		495283	B. WING			07/	18/2019
	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 DEFICIENC)	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 APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F 645	the level of services and (B) If the individual services, whether it specialized services §483.20(k)(2) Exce section- (i)The preadmission paragraph(k)(1) of t for determinations i to a nursing facility being admitted to the transferred for care (ii) The State may oppreadmission screen paragraph (k)(1) of to a nursing facility (A) Who is admitted hospital after received hospital, (B) Who requires not condition for which the hospital, and	requires such level of the individual requires so for intellectual disability. Potions. For purposes of this in screening program under this section need not provide in the case of the readmission of an individual who, after the nursing facility, was in a hospital. The hoose not to apply the this section to the admission of an individual-to the facility directly from a fing acute inpatient care at the the individual received care in	F	645	residents #79, #40, #95 and #61. 2. Residents that are admitted to the facility who are required to have a level 1 PASARR completed have the potential to be affected. 3. Admission Department and Social Services Department were re-educated by the Administrator to ensure level 1 PASARRs are completed. 4. Admissions and/or designee will audit residents who are required to have PASARRs to ensure that level 1 PASARRs are completed daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be August 29, 2019.		8-29-19
	before admission to is likely to require le facility services. §483.20(k)(3) Defin section- (i) An individual is confisorder defined in a (ii) An individual is contellectual disability intellectual disability	g physician has certified, the facility that the individual ss than 30 days of nursing ition. For purposes of this considered to have a mental dual has a serious mental 483.102(b)(1). considered to have an if the individual has an as defined in §483.102(b)(3) a related condition as					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	495283	B. WING			1	C /18/2019
PROVIDER OR SUPPLIER	CES-IMPERIAL		171	19 BELLEVUE AVENUE	011	10/2010
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
described in 435.10 This REQUIREMEN by: Based on staff inte and clinical record r the facility staff faile PASARR (pre-admireview) for four of 5 sample, Residents a The findings include 1. The facility staff fr PASARR was comp was evaluated and a the most integrated resident's needs. Resident #79 was a 7/31/14. Resident # were not limited to s and insomnia (difficat most recent MDS (n assessment with an date) of 7/2/19, code moderately impaired On 7/16/19 at 5:00 p #79's PASARR was staff member) #1 (th On 7/17/19 at 7:37 a	It is not met as evidenced rview, facility document review eview, it was determined that d to complete a level I ssion screening and resident 4 residents in the survey #79, #40, #95 and #61. Example to ensure Resident #79's eleted to ensure the resident receiving care and services in setting appropriate for the editor of the eleteration of the electron of the ele	F 6	45			8-29-19
#79 on 7/16/19.						
	PROVIDER OR SUPPLIER CARE HEALTH SERVI SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From padescribed in 435.10 This REQUIREMENT by: Based on staff interested in the facility staff faile PASARR (pre-admireview) for four of 5-sample, Residents in the facility staff faile PASARR was composed was evaluated and interested in the most integrated resident's needs. Resident #79 was a 7/31/14. Resident #were not limited to sand insomnia (difficient most recent MDS (nassessment with an date) of 7/2/19, code moderately impaired on 7/16/19, review of record failed to reverse on 7/16/19 at 5:00 processed in the facility staff faile of 7/2/19, code moderately impaired on 7/16/19 at 5:00 processed in the facility staff failed to reverse on 7/16/19 at 5:00 processed in the facility staff failed to reverse on 7/16/19 at 7:37 at level I PASARR that	PROVIDER OR SUPPLIER CARE HEALTH SERVICES-IMPERIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 85 described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to complete a level I PASARR (pre-admission screening and resident review) for four of 54 residents in the survey sample, Residents #79, #40, #95 and #61. The findings include: 1. The facility staff failed to ensure Resident #79's PASARR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. Resident #79 was admitted to the facility on 7/31/14. Resident #79's diagnoses included but were not limited to stroke, high blood pressure and insomnia (difficulty sleeping). Resident #79's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/2/19, coded the resident's cognition as moderately impaired. On 7/16/19, review of Resident #79's clinical record failed to reveal a level I PASARR. On 7/16/19 at 5:00 p.m., a request for Resident #79's PASARR was made to ASM (administrative staff member) #1 (the administrator). On 7/17/19 at 7:37 a.m., ASM #1 presented a level I PASARR that was completed for Resident	PROVIDER OR SUPPLIER CARE HEALTH SERVICES-IMPERIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 85 described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to complete a level I PASARR (pre-admission screening and resident review) for four of 54 residents in the survey sample, Residents #79, #40, #95 and #61. The findings include: 1. 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On 7/17/19 at 7:37 a.m., ASM #1 presented a level I PASARR that was completed for Resident to resident the resident that the administrator).	## A BUILDING

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING			TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	CES-IMPERIAL	5.	STREET ADDRESS, CITY, STATE, ZIF 1719 BELLEVUE AVENUE RICHMOND, VA 23227	CODE	<u> </u>	710/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPE	8E	(X5) COMPLETION DATE
F 645	member (OSM) #3, workers at the facili When asked who co #3 stated they are co OSM #3 further state an audit because the When asked if they admission, then who stated, "The social of them if they are not Admissions is suppleask us to do the ass for our hospital liaise has a degree in social supposed to have o stated, "Everyone." An interview was conditionable asked who co #2 stated, "They are admission, at the hoone, we have to conhad started an audit on this. An interview was co 7/17/19 at 2:45 p.m. had found this area of correction into place compliance as all of the missing PASARI	and OSM #4, the social ty, on 7/17/19 at 1:43 p.m. completes the PASARR, OSM completed prior to admission. Seed the facility had just done are were many missing. It do not have one prior to completes them, OSM #3 worker is supposed to do done on admission. Osed to check and they would be sesment. The preference is not ocomplete these as she is in work." When asked who is ne completed, OSM #3 Inducted with OSM #2, (the tor), on 7/17/19 at 2:02 p.m. on pletes the PASARR, OSM is to be done prior to be pospital. If they don't come with a plete it." OSM #2 stated they in 7/16/19, and are working inducted with ASM #1 on ASM #1 stated the facility of concern and had put a plan are but they were still not in the audits and completion of Rs had not been completed. a.m., ASM #1, ASM #2 (the or of nursing) and ASM #3 be consultant) were made	F6	545			8-29-17

	OF CORRECTION	IDENTIFICATION NUMBER:	1 '				MPLETED
		495283	B. WING	i		07	C / 18/2019
	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 645	The facility docume PASARR and Asses PASARR process re Medicaid-certified in for possible serious intellectual disabilitie. The initial pre-scree PASARR Level I, an admission to a nurs. No further information. 2. The facility staff far PASARR was comply was evaluated and in the most integrated resident's needs. Resident #40 was a 9/27/17 with a recent diagnoses that inclustroke, dementia, higher light in decrease clot formation in the resulting in decrease clot formation in the the most recent ME assessment, a quart assessment references ident was severe cognitive decisions. being totally depend members for all of the members for all	int titled, "Coordination of sements" documented, "The sequires that all applicants to ursing facilities be screened mental disorders or es and related conditions. In the sequires that all applicants to ursing facilities be screened mental disorders or es and related conditions. In the sequire to as the scompleted prior to exit. In the sequire that is completed prior to exit. In the sequire that is a sequire that is a sequire that is a sequire to the sequire that is a sequire	F	545			8-29-19

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F 645	the completion of A request was ma member) #1 (the a Resident #40's PAOn 7/17/19 at 7:37 member (ASM) #1 copy of the PASAF was dated 7/16/19 #4, the social work workers at the fact When asked who #3 stated they are OSM #3 further stan audit because to When asked if the admission, then wistated, "The social them if they are not Admissions is suppask us to do the asfor our hospital liai has a degree in so supposed to have stated, "Everyone. completed the PAS #4 stated, "Yesterd An interview was cadmission, on 7/17 who completes the "They are to be do hospital. If they do complete it." OSM	de to ASM (administrative staff administrator) for a copy of SARR on 7/16/19 at 5:00 p.m. 7 a.m. administrative staff , the administrator, presented a RR for Resident #40. The form the transport of the transpo	Fe	645		8-29-19

MANORCARE HEALTH SERVICES-IMPERIAL TOP 10 SUMMARY STATEMENT OF DEFICIENCIES PREFIX PREFIX PROPERTIES EACH DEFICIENCY WIST BETHEVE AVENUE RICHMOND, VA 23227 FREST, TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PROPERTIES EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX TAG FREGULATORY OR LSC IDENTIFYING INFORMATION) FREST, TAG Continued From page 89 this. An interview was conducted with ASM (administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #1, the administrative difference or or or or or or or or or or or or or		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		TE SURVEY MPLETED
MANORCARE HEALTH SERVICES-IMPERIAL Tries BELLEVU AVENUE RICHMOND, VA 23227			495283	B. WING		07	C //18/2019
F 645 F 645 Continued From page 89 this. An interview was conducted with ASM (administrative staff member) #1, the administrative staff member) #1, the administrative director into place but there were still not in compliance as all of the administrative director of nursing, and ASM #3, the quality sacrance consultant were made aware of the above concerns or 7/17/19 at 4:50 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. 3. The facility staff failed to ensure Resident #95's PASARR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident #95 was admitted to the facility 4/17/17 with diagnoses that included but were not limited to: cancer of the larynx, COPD (chronic obstructive pulmonary disease -general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), and schizophrenia [Any of a group of mental disorders characterized by gross			ICES-IMPERIAL		1719 BELLEVUE AVENUE		. 10.2010
this. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 7/17/19 at 2:45 p.m. ASM #1 stated the facility had found this area of concern and have put a plan of correction into place but there were still not in compliance as all of the audits and completing of the missing PASARRs has not been completed. ASM #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant were made aware of the above concerns on 7/17/19 at 4:50 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. 3. The facility staff failed to ensure Resident #95's PASARR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. Resident #95 was admitted to the facility 4/17/17 with diagnoses that included but were not limited to: cancer of the larynx, COPD (chronic obstructive pulmonary disease -general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), and schizophrenia [Any of a group of mental disorders characterized by gross	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
distortions of reality, withdrawal of thought, language, perception and emotional response]	F 645	An interview was co (administrative staf administrator, on 7/stated the facility had and have put a plar there were still not audits and complet has not been compound a summar of the administrative direct the quality assurance aware of the above p.m. No further information. Non-Medical Reade Chapman, page 55 3. The facility staff of PASARR was compound the most integrated resident's needs. Resident #95 was a with diagnoses that to: cancer of the lar obstructive pulmonal chronic, nonreversil a combination of enbronchitis) (1), and of mental disorders distortions of reality	onducted with ASM f member) #1, the /17/19 at 2:45 p.m. ASM #1 ad found this area of concern of correction into place but in compliance as all of the ing of the missing PASARRs leted. istrator, ASM #2, the etor of nursing, and ASM #3, ce consultant were made concerns on 7/17/19 at 4:50 for was obtained prior to exit. ary of Medical Terms for the er, 5th edition, Rothenberg and er, 5th edition, Rothenberg and exit receiving care and services in setting appropriate for the edition of the exit	F 64	45		8-29-4

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING			E SURVEY IPLETED
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F 645	The most recent Massessment, a qual assessment references ident as scoring interview for mental was cognitively into decisions. Review of the clinical the completion of a A request was mad member (ASM) #1, Resident #95's PASON 7/17/19 at 7:37 member (ASM) #1, copy of the PASARI was dated 7/16/19. hospital liaison, who interview. An interview was comember (OSM) #3, workers at the facilial When asked who comember (OSM) #3 stated they are comember to the facilial when asked if they admission, then who stated, "The social of them if they are not the second in the second i	DS (minimum data set) rterly assessment, with an nee date of 7/10/19, coded the a "15" on the BIMS (brief I status) score, indicating he ct to make cognitive daily al record failed to evidence	F6	45			8-29-19
	for our hospital liais	sessment. The preference if on to complete these as she ial work." When asked who is					

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supposed to have of stated, "Everyone." An interview was condamissions, on 7/17 who completes the "They are to be don hospital. If they don complete it." OSM # started an audit on this. An interview was condaministrative staff administrative staff administrative staff administrative staff administrative and have put a plan there were still not it audits and completing has not been completed. ASM #1, the administrative direct the quality assurance aware of the above p.m. No further information. No further information. Hon-Medical Reade Chapman, page 124 (2) Barron's Dictional Non-Medical Reade Chapman, page 522 4. The facility staff facilit	and completed, OSM #3 Inducted with OSM #2, 7/19 at 2:02 p.m. When asked PASARR, OSM #2 stated, e prior to admission, at the It come with one, we have to 2 further stated they had 7/16/19, and are working on Inducted with ASM member) #1, the 17/19 at 2:45 p.m. ASM #1 Indicated the missing PASARRs and a self of the Ing of the missing PASARRs are consultant were made concerns on 7/17/19 at 4:50 In was obtained prior to exit. In ary of Medical Terms for the Interpretation, Rothenberg and Interpretation and Interpr	F6	345			8-29-19
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	PROVIDER OR SUPPLIER CARE HEALTH SERVI SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa supposed to have of stated, "Everyone." An interview was co admissions, on 7/17 who completes the "They are to be don hospital. If they don complete it." OSM # started an audit on this. An interview was co (administrative staff administrator, on 7/1 stated the facility ha and have put a plan there were still not in audits and completin has not been compl ASM #1, the administrative direct the quality assurance administrative direct the facility ha and have put a plan there were still not in administrative direct the facility ha and have put a plan there were still not in administrative direct the facility ha and have put a plan there were still not in administrative direct the facility ha and have put a plan there were still not in administrative direct the facility ha and have put a plan there were still not in administrative direct administrative direct administrative direct administrative direct administrative	PROVIDER OR SUPPLIER CARE HEALTH SERVICES-IMPERIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 91 supposed to have one completed, OSM #3 stated, "Everyone." An interview was conducted with OSM #2, admissions, on 7/17/19 at 2:02 p.m. When asked who completes the PASARR, OSM #2 stated, "They are to be done prior to admission, at the hospital. If they don't come with one, we have to complete it." OSM #2 further stated they had started an audit on 7/16/19, and are working on this. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 7/17/19 at 2:45 p.m. ASM #1 stated the facility had found this area of concern and have put a plan of correction into place but there were still not in compliance as all of the audits and completing of the missing PASARRs has not been completed. ASM #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant were made aware of the above concerns on 7/17/19 at 4:50	PROVIDER OR SUPPLIER CARE HEALTH SERVICES-IMPERIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 91 supposed to have one completed, OSM #3 stated, "Everyone." An interview was conducted with OSM #2, admissions, on 7/17/19 at 2:02 p.m. When asked who completes the PASARR, OSM #2 stated, "They are to be done prior to admission, at the hospital. If they don't come with one, we have to complete it." OSM #2 further stated they had started an audit on 7/16/19, and are working on this. 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The facility staff failed to ensure Resident #61's PASARR was completed to ensure the resident	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 91 supposed to have one completed, OSM #3 stated, "Everyone." An interview was conducted with OSM #2, admissions, on 7/17/19 at 2:02 p.m. When asked who completes the PASARR, OSM #2 stated, "They are to be done prior to admission, at the hospital. If they don't come with one, we have to complete it." OSM #2 further stated they had started an audit on 7/16/19, and are working on this. An interview was conducted with ASM (administrative staff member) #1, the administrative staff member) #1, the administrative alian of correction into place but there were still not in compliance as all of the audits and completed. ASM #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant were made aware of the above concerns on 7/17/19 at 4:50 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. 4. The facility staff failed to ensure Resident #61's PASARR was completed to ensure the resident	PROVIDER OR SUPPLIER A SUNDING BY WING STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) FREGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 91 supposed to have one completed, OSM #3 stated, "Everyone." An interview was conducted with OSM #2, admissions, on 7/17/19 at 2:02 p.m. When asked who completes the PASARR, OSM #2 stated, "They are to be done prior to admission, at the hospital. If they don't come with one, we have to complete the PASARR, OSM #2 stated, "They are to be done prior to admission, at the hospital. If they don't come with one, we have to complete in Complete in PASARR, OSM #3 stated the facility had found this area of concern and have put a plan of correction into place but there were still not in compliance as all of the audits and completed. ASM #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant were made aware of the above concerns on 7/17/19 at 4:50 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. 4. The facility staff failed to ensure Resident #61's PASARR was completed to ensure the resident	A BUILDING 495283 B. WING TREET ADDRESS, CITY, STATE, 2IP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CONTINUED FROM page 91 Supposed to have one completed, OSM #3 stated, "Everyone." An interview was conducted with OSM #2, admissions, on 7/17/19 at 2:02 p.m. When asked who completes the PASARR, OSM #2 stated, "They are to be done prior to admission, at the hospital. If they don't come with one, we have to complete it." OSM #2 further stated they had started an audit on 7/16/19, and are working on this. An interview was conducted with ASM (administrative staff member) #1, the administrative of the missing PASARRs has not been completed. ASM #1, the administrator, ASM #2, the administrator, or 17/17/19 at 2:45 p.m. ASM #1 stated the facility had found this area of concern and have put plan of correction into place but there were still not in compliance as all of the adults and completing of the missing PASARRs has not been completed. ASM #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant were made aware of the above concerns on 7/17/19 at 4:50 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. 4. The facility staff failed to ensure Resident #61's PASARR was completed to ensure the resident

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION NG		OATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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
F 645	the most integrated resident's needs. Resident #61 was a 9/14/16, with diagnorm of limited to: schize mental disorders check distortions of reality language, perception (1), and macular dedegeneration, or agdegeneration [AMD loss in Americans 6 destroys your sharp central vision to see tasks such as readictive memory difficulties. The most recent ME assessment, a quarassessment reference resident as having be memory difficulties. Review of the clinicative completion of a A request was made member (ASM) #1, of Resident #61's Prop.m. On 7/17/19 at 7:37 amember (ASM) #1, copy of the PASARF	setting appropriate for the admitted to the facility on oses that included but were ophrenia (Any of a group of aracterized by gross, withdrawal of thought, on and emotional response) generation [Macular e-related macular], is a leading cause of vision 0 and older. A disease, central vision. You need objects clearly and to do ng and driving] (2). OS (minimum data set) terly assessment, with an oce date of 6/19/19, coded the both short and long-term all record failed to evidence PASARR Level I. The to administrative staff the administrator for the copy ASARR on 7/16/19 at 5:00 a.m. administrative staff the administrator, presented a R for Resident #61. The form This was completed by the	F 64	45		8-29-19
	An interview was co	nducted with other staff				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 645	member (OSM) #3, workers at the facilit When asked who completes the state of they are completed to the stated, "The social them if they are not admission, then who stated, "The social them if they are not admissions is suppleased to the asterior our hospital liais has a degree in social supposed to have completed to the stated, "Everyone." An interview was conditionable of they are to be don hospital. If they don complete it." OSM if started an audit on this. An interview was conditionable of the facility has and have put a plant there were still not in audits and complete the quality assurance the quality assurance the quality assurance of the stated the facility direction of the stated the facility has not been completed the quality assurance the quality assurance the quality assurance of the stated the facility direction of the stated the facility has not been completed the quality assurance the quality assurance the quality assurance the stated the facility assurance the quality assurance the facility assurance the quality assurance the facility assurance the quality assurance the quality assurance the facility assurance the quality assurance the facility assurance the facility assurance the facility assurance the facility assurance the facility assurance the facility assurance the facility assurance the facility assurance the facility assurance the facility as the facility assurance the facility as the faci	ity, on 7/17/19 at 1:43 p.m. completes the PASARR, OSM completed prior to admission. Ited the facility had just done here were many missing. Ited to not have one prior to completes them, OSM #3 worker is supposed to do it done on admission. Ited to check and they would sessment. The preference if item to complete these as she cital work." When asked who is one completed, OSM #3 Inducted with OSM #2, 19 at 2:02 p.m. When asked PASARR, OSM #2 stated, he prior to admission, at the 19 trome with one, we have to 19 february for the mission of concern of correction into place but in compliance as all of the ing of the missing PASARRs	F6	45		8-29-19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	(X:	3) DATE SURVEY COMPLETED
		495283	B. WING			C 07/18/2019
	PROVIDER OR SUPPLIE CARE HEALTH SER			STREET ADDRESS, CITY, STATE, ZIP CO 1719 BELLEVUE AVENUE RICHMOND, VA 23227	DDE	077072070
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 645	(1) Barron's Dictic Non-Medical Rea Chapman, page \$ (2) This information following website: https://vsearch.nlimeta?v%3Aprojemedlineplus-bund-degeneration Develop/Impleme CFR(s): 483.21(b) Comp \$483.21(b) Comp \$483.21(b) (1) The implement a compare plan for each resident rights set \$483.10(c)(3), the objectives and timedical, nursing, needs that are ideassessment. The describe the follow (i) The services the or maintain the rephysical, mental, required under \$4 (ii) Any services the under \$483.24, \$4 (iii) Any services the under \$483.24, \$4 (iii) Any services the content of the conten	ention was obtained prior to exit. In any of Medical Terms for the der, 5th edition, Rothenberg and 522. In was obtained from the m.nih.gov/vivisimo/cgi-bin/query-ct=medlineplus&v%3Asources=lle&query=age-related+macular Int Comprehensive Care Plan (1) In the comprehensive Care Plan (1) In the facility must develop and prehensive person-centered in resident, consistent with the forth at §483.10(c)(2) and includes measurable in the comprehensive care plan must wing and mental and psychosocial entified in the comprehensive comprehensive care plan must wing and psychosocial well-being as 83.24, §483.25 or §483.40; and mat would otherwise be required 183.25 or §483.40 but are not	F 6		n to and it within erein. To federal ter has it forth in ition ition of encies ected by ed	8-29-19
	under §483.10, in treatment under §	ne resident's exercise of rights cluding the right to refuse 483.10(c)(6). Industrial to the right to refuse 483.10(c)(6).				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING		C 07/18/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	BE COMPLETION	
F 656	rehabilitative service provide as a result of recommendations. findings of the PAS, rationale in the resident's represent (iv)In consultation we resident's represent (A) The resident's goodsired outcomes. (B) The resident's pfuture discharge. Fawhether the resident community was associal contact agencientities, for this purp (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on observation interview, facility do record review, it was failed to implement for two of 54 resider Residents #31 and in the findings included to the findings included the findings includ	es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the retire (s)- coals for admission and reference and potential for acilities must document at's desire to return to the ressed and any referrals to research and reference and potential for acilities must document at's desire to return to the ressed and any referrals to research in the comprehensive care and in the comprehensive care at the in paragraph (c) of this section, staff interview, resident cument review, and clinical and determined the facility staff the comprehensive care plan and the survey sample, at the comprehensive care plan and the survey sample, at the care plan for the	F 6	comprehensive person-centered care plan for each resident. 1. Upon notification of surveyor administrative nursing staff were re-educated on accurately reading the oxygen concentrator levels as well as providing non-pharmacological interventions for pain management. 2. Residents who receive PRN pair medication and/or receive oxygen and reside in the facility have the potential to be affected. 3. Director of Nursing and/or designee re-educated the Licensed Nurses and the Interdisciplinary Team (IDT) on the development and implementation of comprehensive personcentered care plan for each resident who receive PRN pain medication and/or oxygen. 4. Director of Nursing and/or designee will audit care plans for residents with new orders for PRN pain medication and/or oxygen daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be August 29, 2019.		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	CON	TE SURVEY MPLETED C	
		495283	B. WING			i	/18/2019	
	PROVIDER OR SUPPLIER	CES-IMPERIAL		17	TREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	8E	(X5) COMPLETION DATE	
F 656	lupus erythematosudisease of unknowr arthritis, a red rash fatigue, and weakned. The most recent MI assessment, a qual assessment referer resident as scoring interview for mental resident was capab decisions. The resident was capab decisions. The resident was capab decisions. The resident was capab decision O- Special Programs, the resident oxygen while a resident vised on 5/27/19, Has/at risk for respictopp (chronic obstate "Interventions" at 2 liters via nasal of the "Interventions" at 2 liters via nasal of the was connected to a oxygen concentrato with the top of the bear minute) line and 1.5 LPM line. A second the same day at 2:4 set as it was during	is [chronic inflammatory in cause. Symptoms include over the nose and cheeks, ess] (1). DS (minimum data set) of terly assessment, with an ince date of 5/17/19, coded the a "14" on the BIMS (brief is status) score, indicating the le of making daily cognitive dent was coded as requiring totally dependent upon one of activities of daily living. In the treatments, Procedures and lent was coded as using dent in the facility. Treatments, Procedures and lent was coded as using dent in the facility. The care plan dated 10/1/18 and documented in part, "Focus: ratory impairment related to tructive pulmonary disease)." documented in part, "Oxygen cannula." The resident #31 on the late of Resident #31 on the late on via a nasal cannula [a late inserts into the nose] that in oxygen concentrator. The relow meter was observed all set on the 2.0 LPM (liters of the bottom of the ball on the lond observation was made on 4 p.m. and the oxygen was the first observation.	F6				8-29-19	
		ade of Resident #31 on						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING			C 		
	PROVIDER OR SUPPLIER			171	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE CHMOND, VA 23227	1 011	10/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 656	on. The oxygen coobserved with the to LPM (liters per miniball on the 1.5 LPM). The physician orde "O2 (oxygen) @ (at cannula every shift breath)." An interview was copractical nurse) #3 #3 was asked to obin use by Resident the oxygen was set 2 LPM. When asked on the oxygen concept ball has to be on the An interview was costaff member (ASM) director of nursing, asked how the staff the oxygen concent line of the prescribed center of the ball." The manufacturer's part, "To properly represcribed flowrate turn the flow knob unow, center the ball." Administrative staff administrator, ASM of nursing, and and and a control of the nursing and asM of nursing, and ASM of nursing, and ASM of nursing, and as a control of the nursing and as a control of the nursing and a control	ncentrator flow meter was op of the ball set on the 2.0 ute) line and the bottom of the line. I dated, 1/14/19, documented, 2 liters per minute via nasal for SOB (shortness of onducted with LPN (licensed on 7/17/19 at 3:22 p.m. LPN serve the oxygen concentrator #31. When asked what rate at, LPN #3 stated it was set at d how you set the flowmeter entrator to the physician N #3 stated, "The top of the exprescribed line." Inducted with administrative on 7/17/19 at 4:50 p.m. When read an oxygen flowmeter on rator, ASM #2 stated, "The d rate has to go through the line on the flowmeter. Next, ntil the ball rises to the line. I on the LPM line prescribed." I member (ASM) #1, the #2, the administrative director #3, the quality assurance de aware of the above	F	556			8-29-19	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l''		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING		<u> </u>	1	/18/2019	
	PROVIDER OR SUPPLIER	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 PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	conducted with RN was asked the purp confirmed the care resident care needs care plan should be needed. The facility policy, "Planning" document The patient's care pthat guides membe healthcare team in patient's needs. It a methods of care the receiveImplement developed, the staff interventions identifinay include, but is treatments and meetherapies, and partipatient." No further informati (1) Barron's Dictional Non-Medical Reade Chapman, page 5502. The facility staff 59's care plan for the	l a.m., an interview was (registered nurse) #3. RN #3 lose of a care plan. RN #3 plan is used to communicate to staff. RN #3 stated the followed and revised as Interdisciplinary Care ted in part, "Care Planning: lan is a communication tool rs of the interdisciplinary how to meet each individual lso identifies the types and at the patient should tation: Once the care plan is must implement the ied in the care plan. These not limited to: administering dications, performing cipating in activities with the on was obtained prior to exit. ary of Medical Terms for the er, 5th edition, Rothenberg and	F 6	56			8-29-12	
	4/7/2017 with a read diagnoses that incluchronic obstructive	edication. admitted to the facility on draining of the facility on draining of the facility on draining of the facility on draining of the facility of the fa						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				TE SURVEY MPLETED	
		495283	B. WING			С
NAME OF	PROVIDER OR SUPPLIER	433203		STREET ADDRESS, CITY, STATE, ZIP CODE	0/	//18/2019
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 PREFI) TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 656	unspecified bronched disorder (3). Reside (minimum data set) an ARD (assessme coded Resident # 5 assessment for merof 0 - 15, 15- being daily decisions. Set as having pain frequency on 07/16/19 at 2:38 conducted with Resident was asked if the star giving him an as nerolled the second with the second with the second with the second with the second with the second with the POS (physician "07/18/2019" for Retain medication Resident # 59 states and ask me a number try to alleviate his papain medication Resident # 59 states and ask me a number try to alleviate his papain medication Resident # 59 states (five) mg (milligrams hours as needed for 04/26/2019. Start Decent for the email of the e	us or lung (2) and anxiety ent # 59's most recent MDS, a quarterly assessment with not reference date) of 06/18/19, 9 as scoring a 15 on the staff intal status (BIMS) of a score cognitively intact for making ection J coded Resident #59 uently. 8 p.m., an interview was ident # 59. Resident # 59 ident # 59. Resident # 59 ident # 59 ident # 59 ident # 59 ident # 59 ident # 59 ident # 59 ident # 59 ident # 59 ident # 59 stated, "No." Is order sheet) dated if the staff in prior to administering the sident # 59 stated, "No." Is order sheet) dated is order sheet) dated is order sheet in dated in prior to administering the sident # 59 ident # 59	F 6	56		8-29-19

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
	i	495283	B. WING	·		07	C /18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL	,	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	p.m.), 07/09/19 at 05:08 (5 p.m.), 07/10/19 at 05:00 (5 and 21:58 (9:58 p.m 07/11/19 at 05:17 (5 p.m.), 07/12/19 at 05:10 (5 p.m.), 07/13/19 at 05:17 (5 p.m.), 07/13/19 at 05:17 (5 p.m.), 07/14/19 at 05:28 (5 07/15/19 at 05:25 (5 7/16/19 at 05:26 (5 p.m.), 07/17/19 at 05:45 (5 p.m.), 07/17/19 at 05:42 (5 p.m.), 07/18/19 at 05:43 (5 p.m.), 07/18/19 at 05:43 (5 p.m.), 07/18/19 at 05:43 (5 p.m.), 07/18/19 at 05:43 (5 p.m.), 07/18/19 at 05:43 (5 p.m.), 07/18/19 at 05:45 (5 p.m.	5:09 a.m.), 4:54 a.m.), (5:11 a.m.) and 21:26 (9:26 5:08 a.m.) and 20:45 (8:45 5:00 a.m.), 13:09 (1:09 p.m.) a.), 5:17 a.m.) and 21:38 (9:38 5:10 a.m.) and 20:55 (8:55 5:17 a.m.) 12:53 p.m. and 5:28 a.m.) and 12:38 p.m., 5:15 a.m.), 20 a.m.) and 21:54 (9:54 5:45 a.m.) and 22:15 (10:15 6:42 a.m.). e eMAR dated "Jul (July) R notes dated 07/01/19 filed to evidence on-pharmacological of the administration of the dates. care plan for Resident # 59 ocumented, "The resident is Therapy r/t (related to) of lung." Date Initiated on on: 12/11/2018." Under	F6	356			8-29-19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		LE CONSTRUCTION	COMPLETED	
		495283	B. WING				C /18/2019
	PROVIDER OR SUPPLIER	ICES-IMPERIAL	v	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	8	10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 656	On 07/18/19 at 12:conducted with RN asked to describe t administration of pr stated, "We ask wh (one) to 10 (ten), w nonverbal, and che administration reco positioning, get the visual imaging befo documentation of trinterventions, RN # documented when (medication)." Whe RN #2 stated, "For interdepartmental, witherapy), not just not incident happens at When asked should interventions in the that is true." RN #2 implementing the control interventions are not "That is true." On 7/18/19 at 12:57 conducted with RN asked to describe the administration of prestated, "We ask who offer non-pharmacowere not successful have, check the MA record) and the drug care plan- interventions RN #3 interventions RN #3 interventions RN #3	45 p.m., an interview was (registered nurse) # 2. When the procedure for the region pain medication, RN # 2 the use other pain scales if the MAR (medication rd). We offer other things, out of the room, music, or re meds." When asked about the non-pharmacological 2 stated, "It is usually giving a prn (as needed) med an asked to define a care plan	F	656			8-29-19

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		1	C 1 8/2019
	PROVIDER OR SUPPLIER	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 011	10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)) BE	(X5) COMPLETION DATE
F 656	non-pharmacologic of the eMAR notes 2019, RN #3 agreed interventions were retimes Roxicodone versioned documented above been told to try non-before meds [medic write a progress not them before you give should staff follow in RN #3 stated, "Staff the care plan." RN implementing/follow documented interversioned interversi	al interventions." After review for Resident #59 dated July d that non-pharmacological not attempted on dates and was administered as RN #3 stated, "We have pharmacological interventions rations], typically when you see there is a box to document the meds." When asked interventions in the care plan, is should follow interventions in #3 agreed that staff are not	F 6	56		8-29-19
7	documented, "Phas interdisciplinary tear plan to focus on all cincluding those assorting the patient guardian is included build on past successaked for suggestion have successfully usplan." On 07/18/19 at appropriate (administrator) and a director of nursing) of findings.	Pain Practice Guide" e 2: Plan. The m designs the patient's care of the patient's issues ociated with pain symptoms. Interview and family or legal to maintain consistency and asses. Caregivers are also as about interventions they sed in managing a patient's asymptotic particular of the con was provided prior to exit.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING	·		07	C /18/2019
	PROVIDER OR SUPPLIER	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227			710/2013
(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 APPROPRIED DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	(COPD) Disease that makes lead to shortness of obtained from the whttps://www.nlm.nih 2. Malignant neopla The term "malignan cancerous cells that other sites in the bonearby (locally) and cells tend to have fado NOT die norma genetic makeup. M resistant to treatmed detectable traces of destroyed. This in the website: https://medlineplus.g. 3. Anxiety Fear. This informat website: https://www.nlm.nih.#summary.	tive pulmonary disease s it difficult to breath that can f breath. This information was rebsite: .gov/medlineplus/copd.html.	F	356			8-29-19
	moderate to severe extended-release ta capsules are used to people who are experienced around the clock for be treated with othe information was obtained.	blets and extended-release o relieve severe pain in ected to need pain medication a long time and who cannot					

	D PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495283	B. WING			07	C //18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI			1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 657 SS=D	§483.21 (b) Compres §483.21 (b) (2) A compres §483.21 (b) (2) A compres §483.21 (b) (2) A compres §483.21 (b) (2) A compres §483.21 (b) (2) A compres §483.21 (b) Compres §483.21 (c) Property of the attending property of the extendent of the resident. (C) A nurse aide with resident. (D) A member of form (E) To the extent property of the extent property of the resident and the resident resident resident resident's care plant (F) Other appropriate disciplines as determined and resident residents. This REQUIREMED by: Based on observation disciplines are assessments. This REQUIREMED by: Based on observation and review	chensive Care Plans imprehensive care plan must in 7 days after completion of assessment. interdisciplinary team, that imited to inhysician. Itse with responsibility for the interdisciplinary team, that imited to inhysician. Itse with responsibility for the ind and nutrition services staff. Itsecticable, the participation of the resident's representative(s). Itse included in a resident's the participation of the resident tepresentative is determined the development of the interdisciplinary the staff or professionals in imined by the resident's needs the resident. The including both the indical record review, it is not met as evidenced tion, staff interview, facility and clinical record review, it at the facility staff falled to the comprehensive care plan tents in the survey sample,	F	657	F – 657 The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated it is the intended practice of this facility to review and/or revise the care plans of each resident after each assessment.	n () () () ()	8-29-19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495283	B. WING _				C 07/18/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	CES-IMPERIAL		1719	EET ADDRESS, CITY, STATE, ZIP CO BELLEVUE AVENUE HMOND, VA 23227	ODE	01710/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		
F 657	The findings included. 1. The facility staff of Resident #64's concuse of a palm protes. Resident #64 was a 11/4/14. Resident were not limited to high cholesterol. Finding the many many many many many many many many	failed to review and revise aprehensive care plan for the actor. admitted to the facility on #64's diagnoses included but diabetes, heart disease and esident #64's most recent a set), a quarterly assessment asment reference date) of resident's cognitive skills for any as severely impaired. esident #64 as being totally staff with dressing. p.m. and 7/17/19 at 12:40 was observed lying in bed. A evice placed on the hand to from touching the palm) was sident's left hand. Review of aprehensive care plan dated ecument information regarding	F 6	57	 Upon notification of su on 7-18-19, administra nursing staff were ree on reviewing and revis comprehensive care pl Residents that reside it facility who require the assisted devices and/o falls have the potential affected. Director of Nursing and designee to re-educate Licensed Nurses and the care plan timing an revision. Director of Nursing and designee will audit car regards to falls as well auditing care plans in special equipment needs a days, then three day x 3 weeks and then months. Results of the audits will be reviewed facility's QAA Commit Recommendations will discussed and implement needed. The facility's alteged compliance will be A 2019. 	ative educated sing the lan. In the e use of or have if to be d/or e the if (IDT) on if as regards to eds daily x ys a week onthly x 2 e QAA d by the stee. If be enented as	8-29-19	

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COM	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	· I	JLD BE	(X6) COMPLETION DATE
F 657	aware of the above The facility docume "INTERDISCIPLINA documented, "The communication too interdisciplinary he each individual pati the types and meth should receive" No further informat 2. The facility staff Resident #79's con resident fell on 2/2" Resident #79 was 7/31/14. Resident were not limited to and insomnia (diffic most recent MDS (assessment with a date) of 7/2/19, coc moderately impaire #79 as sustaining t since the previous Review of Residen fall investigations a that on 2/21/19 the on 4/28/19 was obs review of fall invest Resident #79's con 7/31/14, failed to re comprehensive car	arance consultant) were made of concern. Ent titled, ARY CARE PLANNING" patient's care plan is a self that guides members of the althcare team in how to meet dent's needs. It also identifies nods of care that the patient sion was presented prior to exit. If alled to review and revise apprehensive care plan after the 1/19 and 4/28/19. Endmitted to the facility on #79's diagnoses included but stroke, high blood pressure culty sleeping). Resident #79's minimum data set), an annual of ARD (assessment reference ded the resident's cognition as add. Section J coded Resident wo or more falls with no injury	F 6	557		8-29-19

F CORRECTION	IDENTIFICATION NUMBER;				(X3) DATE SURVEY COMPLETED	
	495283	B. WING				C 18/2019
PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		1	719 BELLEVUE AVENUE	<u>, 077</u>	10/2019
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
On 7/17/19 at 4:00 conducted with LPN LPN #1 was asked LPN #1 stated, "To When asked what stalls, LPN #1 stated implement a new in the new intervention the care plan. On 7/18/19 at 11:55 staff member) #1 (I (the administrative #3 (the quality assuaware of the above No further informat Services Provided I CFR(s): 483.21(b)(3) Com The services provided Services provided Services provided I CFR(s): 483.21(b)(3) Com The services provided Services provided Services provided I CFR(s): 483.21(b)(3) Com The services provided Services p	p.m., an interview was I (licensed practical nurse) #1. the purpose of the care plan. track treatments and stuff." should be done after a resident I, "Update the care plan and Intervention." LPN #1 stated In should be documented on I a.m., ASM (administrative I he administrator), ASM #2 director of nursing) and ASM I arance consultant) were made I concern. I on was presented prior to exit. Meet Professional Standards I (i) I prehensive Care Plans I ded or arranged by the facility, I comprehensive care plan, I standards of quality. I is not met as evidenced I ion, staff interview, facility I ind clinical record review, it I facility staff failed to follow I ards of practice for the Cations for one of 54 residents I e medication carts.			correction are not an admission to all do not constitute an agreement with the alleged deficiencies cited herein. remain in compliance with all federa and state regulations, the center had taken or will take the actions set forth the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected the date or dates indicated it is the intended practice of this facil	nd in To si s in in f t t t t t t t t t t t t t t t t t t	8-29-19
1. The facility staff t	ailed to clarify the indication of					
	Continued From particles (EACH DEFICIENCY REGULATORY OR L.) Continued From particles (EACH DEFICIENCY REGULATORY OR L.) Continued From particles (EACH DEFICIENCY REGULATORY OR L.) Continued From particles (EACH DEFICIENCY REGULATORY OR L.) Continued From particles (EACH DEFICIENCY REGULATORY OR L.) Continued From particles (EACH DEFICIENCY OR L.) (In the saked what is falls, LPN #1 stated, "To When asked what is falls, LPN #1 stated, "To When asked what is falls, LPN #1 stated, implement a new intervention the care plan. On 7/18/19 at 11:58 staff member) #1 (I (the administrative #3 (the quality assuaware of the above was determined the professional standard administering mediand for one of three The findings included the professional standard administering mediand for one of three The findings included the professional standard administering mediand for one of three The findings included the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard administering mediand for one of three the professional standard admini	### A95283 PROVIDER OR SUPPLIER CARE HEALTH SERVICES-IMPERIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 107 On 7/17/19 at 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the purpose of the care plan. LPN #1 stated, "To track treatments and stuff." When asked what should be done after a resident falls, LPN #1 stated, "Update the care plan and implement a new intervention." LPN #1 stated the new intervention should be documented on the care plan. On 7/18/19 at 11:55 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the administrative director of nursing) and ASM #3 (the quality assurance consultant) were made aware of the above concern. No further information was presented prior to exit. Services Provided Meet Professional Standards CFR(s): 483.21(b)(3) (i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	ROVIDER OR SUPPLIER CARE HEALTH SERVICES-IMPERIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 107 On 7/17/19 at 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the purpose of the care plan. LPN #1 stated, "To track treatments and stuff." When asked what should be done after a resident falls, LPN #1 stated, "Update the care plan and implement a new intervention." LPN #1 stated the new intervention should be documented on the care plan. On 7/18/19 at 11:55 a.m., ASM (administrative staff member) #1 (the administrative director of nursing) and ASM #3 (the quality assurance consultant) were made aware of the above concern. No further information was presented prior to exit. Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow professional standards of practice for the administering medications for one of 54 residents and for one of three medication carts. The findings include:	A BUILDING 495283 B. WING PROVIDER OR SUPPLIER CARE HEALTH SERVICES-IMPERIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 107 On 7/17/19 at 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the purpose of the care plan. LPN #1 stated, "To track treatments and stuff." When asked what should be done after a resident falls, LPN #1 stated, "Update the care plan and implement a new intervention." LPN #1 stated the new intervention. "LPN #1 stated the care plan. On 7/18/19 at 11:55 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the administrative director of nursing) and ASM #3 (the quality assurance consultant) were made aware of the above concern. No further information was presented prior to exit. Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(I) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow professional standards of practice for the administering medications for one of 54 residents and for one of three medication carts. The findings include:	### A BUILDING ### A BUILDING ### A BUILDING ### BELLEVUE AVENUE **STREET ADDRESS, CITY, STATE, ZIP CODE ### TIPE BELLEVUE AVENUE ### SUMMARY STATEMENT OF DEFICIENCIES ### (EACH DEPICIENCY MUST BE PRECEDED BY PULL. ### REGULATORY OR LSC IDENTIFYING INFORMATION) **CONTINUED From page 107 **CONTINUED From page 107 **CONTINUED FROM PROPER ACTION SHOULD. **LPN #1 stated, "To track treatments and stuff." ### When asked the purpose of the care plan. **LPN #1 stated, "To track treatments and stuff." ### When asked what should be done after a resident falls, LPN #1 stated, "Lpdate the care plan and implement a new intervention." LPN #1 stated the new intervention." LPN #1 stated the new intervention." LPN #1 stated the ear plan and implement a new intervention." LPN #1 stated the quality assurance consultant) were made aware of the above concern. No further information was presented prior to exit. Services Provided Meet Professional Standards **CFR(s): 483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (f) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: ### Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff falled to follow professional standards of practice for the administering medications for one of 54 residents and for one of three medication carts. **The findings include:** **The stretements made on this plan of correction are not an admission to an administering medications for one of 54 residents and for one of three medication carts. **The stretements made on this plan of correction are not an administering the correction of the determination of the correction of the correction of the determination of the correction of the determination of the correction of the determination of the correction of the determination of the correction of the determination of the correction of the determinati	### ABUIDING ### 495283 ### ABUIDING ### ABU

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY
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MANOR(PROVIDER OR SUPPLIER CARE HEALTH SERVI SUMMARY STA	TEMENT OF DEFICIENCIES	·	171	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE CHMOND, VA 23227 PROVIDER'S PLAN OF CORRECT		/18/2019
PRÉFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 658	a medication for Resident #3 was as 2/20/19 with diagnoral limited to: chronic of [COPD - general te lung disease that is emphysema and cholood pressure, and The most recent Mil assessment, a qual assessment referencesident as scoring interview for mental resident is capable decisions. The resident is capable decisions. The resident is capable decisions. The resident is capable decisions. The resident is capable decisions. The resident is capable decisions. The resident is capable decisions. The resident is capable decisions. The resident is capable decisions. The resident is capable decisions. The resident is capable decisions. The resident is capable decisions. The resident is capable decisions. The resident in capable decisions is capable to the interview disorders in the comprehensive documented in part effects related to: us "Interventions" documented in part effects r	dmitted to the facility on sees that included but were not obstructive pulmonary disease rm for chronic, nonreversible usually a combination of aronic bronchitis] (1), high anxiety disorder. OS (minimum data set) reterly assessment, with an noce date of 7/13/19, coded the a "15" on the BIMS (brief status) score, indicating the of making daily cognitive dent was coded in Section Nelving an antianxiety in days of the look-back of dated, 2/20/19, documented, drochloride) 15 mg mg by mouth two times a spirone is used to treat expirate the above physician of care plan dated, 2/28/19, "Focus: At risk for adverse se of antianxiety." The amented in part. "Meds	F6	558	 Upon notification of survey on 7-18-19 administrative nursing staff were re-educated on clarifying the indication medications. Residents who reside in the facility have the potential traffected. Director of Nursing and/or designee to educate Licens nursing staff on clarifying the indication of medications. Director of Nursing and/or designee will audit new medication orders for clarification of proper diagraph daily x 5 days, then three diagraph week x 3 weeks and then monthly x 2 months. Result the QAA audits will be revise by the facility's QAA Committee. Recommendati will be discussed and implemented as needed. The facility's alleged date of compilance will be August 2 2019. 	ted of be ed ee osis ys a s of wed ons	3-29-19

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/30/2019 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ C 495283 B. WING 07/18/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE MANORCARE HEALTH SERVICES-IMPERIAL RICHMOND, VA 23227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X8) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 11-15-18 F 658 Continued From page 109 F 658 what Buspirone is used for, RN #4 stated, "It's used for anxiety." When asked if the order says to give it for COPD, is that correct, RN #4 stated, "No." When asked what should be done with that order, RN #4 stated, "It needs to be clarified." An interview was conducted with LPN (licensed practical nurse) #4 on 7/18/19 a t 10:20 a.m. When asked what Buspirone is used for, LPN #4 stated, "Inflammation. No, it's for high blood pressure." An interview was conducted with administrative staff member (ASM) #2, the administrative director of nursing, on 7/18/19 at 10:22 a.m. When asked what Buspirone is used for, ASM #2 stated, "I haven't been on a med (mediation cart) for some time but I know it's a psychotropic and it's either for anxiety or some kind of psychosis." When asked if the order says to give it for COPD, is that correct, ASM #2 stated, "No." When asked what should be done with that order, ASM #2 stated, "It needs to be clarified." When asked which professional standards of practice the facility follows, ASM #2 stated the follow their policies and Perry and Potter, Fundamentals of Nursina."

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

The facility policy, "Orders Management Matrix" documented in part, "Orders are transcribed or electronically entered then noted by the licensed nurse. The licensed nurse noting an order is responsible for accurate transcription."

According to Fundamentals of Nursing, 6th edition Potter and Perry, 2005, page 846, "A medication order is required for any medication to be administered by a nurse...If the medication order is incomplete, the nurse should inform the

Event ID: U0F411

Facility ID: VA0154

If continuation sheet Page 110 of 142

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
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F 658	carrying out any me (1) Barron's Diction Non-Medical Reade Chapman, page 12 (2) This information following website: https://medlineplus. tml 2. Observation of I revealed pre-poure without identificatio or what the medica On 07/18/19 at 11:: 1's medication cart (licensed practical if the medication cart drawer. Upon oper medication cup was drawer with four pil cup. Further obser identification of the identification of the to be administered An interview was in LPN # 4 about the # 4 stated, "I prepa Resident) and he d asked me if he cou after about 30 minu would take them wi appointment so I pi locked it. When as identifying informat were or whom they	are completeness before edication order." mary of Medical Terms for the er, 5th edition, Rothenberg and 4. It was obtained from the egov/druginfo/meds/a688005.h Unit 1's medication cart # 2 d medication in the top drawer in of whose medication it was ations were. 35 a.m., an observation of Unit # 2 was conducted with LPN incres) # 4. LPN # 4 unlocked and opened the top left and opened the top left ing the drawer, a plastic is observed sitting in the it and one capsule inside the vation failed to evidence any medications in the cup or resident the medications were		658			8-29-19	

	FCORRECTION	IDENTIFICATION NUMBER:		9	СОМ	PLETED
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F 658	medication administ the medications in to the medications in to the medications in the medications in the medications in the medication and some - Furosemide fluid retention and some - Omeprazole heartburn], One - Finasteride 5 prostrate] and one iron]. LPN #4 was standard of practice store them in the madministration later believe they should to discard them and comes back." On 07/18/19 at 12:5 conducted with ASM member) #2, direct describe the processional standard follows, ASM #2 stand Perry & Potter. On 07/18/19 at app (administrative staff administrator, and A were made aware of the medication in the medicatio	bked up the eMAR (electronic tration record) and identified the cup as follows: (milligrams), [blood thinner], 40mg - [diuretic, used to treat swelling], 20mg - [used to treat mg - [treats enlarged Folic Acid 1mg - [treats low asked if it was a nursing endication cart to a compared the stored like that. I'm going if re-administer them when he compared to for of nursing. When asked to the stored like that that have are refused by the resident, they should be discarded and when asked what ard of practice the nursing staff atted, "We follow our policies to the above findings.	F 65	F - 677		8-29-19
F 677 SS=D	No further Informati ADL Care Provided CFR(s): 483.24(a)(on was provided prior to exit. for Dependent Residents 2)	F 67	The statements made on this plan	and	8-29-47

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	CON	E SURVEY (PLETED
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	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-IMPERIAL		1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	<u> </u>	10/2019
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F 677	out activities of dail services to maintail personal and oral if This REQUIREMED by: Based on resident facility document receive, it was determed as determed as being defend	sident who is unable to carry y living receives the necessary n good nutrition, grooming, and hygiene; NT is not met as evidenced interview, staff interview, eview and clinical record rmined the facility staff failed to aily living) assistance for one dents, (Resident #7) who was bendant on staff for bathing.	F (677	the alleged deficiencies cited herein. The remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. It is the intended practice of this facilit to ensure residents who are unable to carryout activities of daily living receivation, grooming, and personal and oral hygiene. 1. Upon notification of surveyor facility staff ensured showers were on the tasks for resident #7. 2. Residents who are dependent of staff for bathing have the potention to be affected. 3. Director of Nursing and/or design to re-educate Nursing staff on ensuring resident showers are completed. 4. Director of Nursing and/or design will audit showers daily x 5 day, and then 3 days a week x 3 week and then monthly x 2 months. The results of the random audits will reported to the QAA Committee for the QAA Committee for the quality is alleged date of compliance will be August 29, 20.	t in f y ty co ve odd ree e e e e e e e e e e e e e e e e e	8-29-19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 677	During an interview at 2:20 p.m., she st showers a week. We get them, Resident they don't have end A request was mad Resident #7's show on 7/18/19 at approadministrative staff administrative direct sheets of paper. The 5/8/19 - Resident reference for the sheets of paper. The 5/8/19 - Resident reference for the sheets of paper. The 5/8/19 - nothing domark next to abnow 6/14/19 - A check me 7/2/19 - nothing was ASM #2 was asked evidence the reside showers. An interview was conursing assistant) # When asked how of shower, CNA #4 states showers a week and one, then we are obtained in the shower of th	with Resident #7 on 7/16/19 ated that she did not get two hen asked why she doesn't #7 stated, "They always say bugh staff." e for documentation of ters for the past three months eximately 9:45 a.m. eximately 12:00 p.m., member (ASM) #2, the stor of nursing, presented three tery documented the following: of used shower. Stumented other than a check	F 67			8-29-19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495283	B. WING		C 07/18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 689 SS=D	stated she had no oprogram of Resider no more shower showe	documentation in the computer at #7's showers and she had eets to present. Bathing" was reviewed. The in part, "Procedure" Verify hedule." There was no he frequency of showers. administrative staff member of #2, the administrative and ASM #3, the quality and, were made aware of the 7/18/19 at 4:25 p.m. ion was obtained prior to exit. ary of Medical Terms for the er, 5th edition, Rothenberg and 0. azards/Supervision/Devices 1)(2) ats. issure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced rview, facility document review	F 68	F – 689 The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated it is the intended practice of this facility	
	the facility staff faile to prevent accidents	review, it was determined that ad to implement interventions is for one of 54 residents in the sident #79. The facility staff		to ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	i

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/30/2019 **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 495283 B. WING 07/18/2019 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 (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) F 689 Continued From page 115 F 689 1. Resident #79 no longer failed to address and/or implement interventions resides at facility, to prevent falls after Resident #79 fell on 2/21/19 2. Residents who reside in the and 4/28/19. facility who have had a fall have the potential to be affected. The findings include: 3. Director of Nursing and/or designee to re-educate Nursing staff on implementing interventions Resident #79 was admitted to the facility on to reduce fall risks. 7/31/14. Resident #79's diagnoses included but 4. Director of Nursing and/or were not limited to stroke, high blood pressure designee to audit falls daily and insomnia (difficulty sleeping). Resident #79's x 5 days and then 3 days a most recent MDS (minimum data set), an annual week x 3 weeks and then assessment with an ARD (assessment reference monthly x 2 months. The date) of 7/2/19, coded the resident's cognition as results of the random moderately impaired. Section J coded Resident audits will be reported to #79 as sustaining two or more falls with no injury the QAA Committee for since the previous assessment. review and follow up recommendations as Review of Resident #79's clinical record revealed indicated. 5. The facility's alleged date of fall investigations and/or nurses' notes revealed

the care plan.

that on 2/21/19 the resident slid off the bed and

on 4/28/19 was observed on the floor. Further review of fall investigations, nurses' notes and Resident #79's comprehensive care plan dated 7/31/14 failed to reveal interventions to prevent futures falls were addressed and/or implemented.

after the 2/21/19 and 4/28/29 falls.

On 7/17/19 at 4:00 p.m., an interview was

conducted with LPN (licensed practical nurse) #1. When asked what should be done after a resident falls, LPN #1 stated, "Update the care plan and implement a new intervention." LPN #1 stated the new intervention should be documented on

On 7/18/19 at 11:55 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2

compliance will be August

29, 2019,

		(X3) DATE SURVEY COMPLETED			
		495283	B. WING		C 07/18/2019
	PROVIDER OR SUPPLIER	/ICES-IMPERIAL	:	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLÉTION
F 689 F 695 SS=D	#3 (the quality ass aware of the above the above the above the above the accumented, "Sor may be associated may need to be recongoing fall preventactor management consumptoms, review effects, review of lidentification and in patient condition."	director of nursing) and ASM surance consultant) were made e concern. ent tiled, "Falls Practice Guide" ne environmental factors which d with falls or the risk of falling viewed and considered as nation strategiesSome risk not interventions that can be eldered as ongoing potential fall ies include, but are not limited of co-morbidities and disease of medications to identify side aboratory test results, management of acute changes	F 6	F – 695 The statements made on this plan correction are not an admission to do not constitute an agreement will the alleged deficiencies cited herein remain in compliance with all fede and state regulations, the center he taken or will take the actions set for the following plan of correction constitutes the center's allegation compliance. All alleged deficiencies cited have been or will be corrected the date or dates indicated it is the intended practice of the fact to provide respiratory care and services consistent with professional standard.	and thin To ral ras th in of es I by ility ices rds 8-29-12
	tracheostomy care The facility must e needs respiratory care and tracheal care, consistent w practice, the comp care plan, the resi and 483.65 of this This REQUIREME by: Based on observa document review a was determined th respiratory care co	atory care, including and tracheal suctioning. Insure that a resident who care, including tracheostomy suctioning, is provided such ith professional standards of trehensive person-centered dents' goals and preferences, subpart. ENT is not met as evidenced ation, staff interview, facility and clinical record review, it e facility staff failed to provide ensistent with professional ice, and the comprehensive		on 7-17-19, admin nursing si were re-educated on proper reading oxygen concentrator flow meters. 2. Residents that are on oxyger and reside in the facility have the potential to be affected. 3. Director of Nursing and/or designee to re-educate Nursistaff on respiratory care and services consistent with professional standards of practice. 4. Director of Nursing and/or designee will audit residents who are on oxygen daily x 5 days and then 3 days a week weeks and then monthly x 2 months. The results of the	taff iv n e ing

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PRINTED	D: 07/30/2019 MAPPROVED
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		495283	B. WING _		07	C //18/2019
MANORO	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		710/2019
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F 695	sample, Resident #3 administer oxygen to physician's order.	54 residents in the survey 31. The staff failed to o Resident #31 per the	F 69	random audits will be repo to the QAA Committee for review and follow up recommendations as Indica 5. The facility's alleged date of compliance will be August 2019.	FORM OMB NO (X3) DA (CO) OTO (X3) DA (CO) OTO (X3) DA (CO) OTO (X3) DA (CO) OTO (X3) DA (X3) DA (X3) DA (X3) OTO (X3) DA (X3) DA (X3) OTO (X3) DA (X3) DA (X3) OTO (X3) DA (X3) DA (X3) OTO (X3) DA (X3) DA (X3) OTO (X3) DA (X3) DA (X3) OTO (X3) DA (X3) DA (X3) OTO (X3) DA (X3) DA (X3) OTO (X3) DA (X3) DA (X3) OTO (X3) DA (X3) DA (X3) OTO (X3) DA (X4) OTO (X	8-29-19
	9/5/18 with a readm diagnoses that inclu high blood pressure lupus erythematosus disease of unknown arthritis, a red rash of fatigue, and weakne. The most recent MD assessment, a quark assessment referencesident as scoring a interview for mental resident was capable decisions. The resident was capable of the compression of the programs, the resident programs, the resident programs, the resident programs, the resident programs, the resident programs, the resident programs, the resident programs of the physician order programs. The physician order programs of the physician order programs, the resident programs or the physician order programs. The physician order programs or the physician order p	dmitted to the facility on ission on 12/26/18, with ded but were not limited to: , chronic pain, and systemic is [chronic inflammatory cause. Symptoms include over the nose and cheeks, iss] (1). 2S (minimum data set) terly assessment, with an ce date of 5/17/19, coded the a "14" on the BIMS (brief status) score, indicating the e of making daily cognitive ent was coded as requiring totally dependent upon one activities of daily living. In reatments, Procedures and ent was coded as using				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		171	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE CHMOND, VA 23227	<u> </u>	10/20 13
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	`	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	The "Interventions" at 2 liters via nasal observation was m 7/16/19 at approxim was in bed, with ox two-pronged tube the was connected to a oxygen concentrate with the top of the bear minute) line and 1.5 LPM line. A sect the same day at 2:4 set as it was during observation was m 7/17/19 at 9:27 a.m on. The oxygen colobserved with the total on the 1.5 LPM An interview was copractical nurse) #3 was asked to obin use by Resident arate the oxygen was set at 2 LPM (liters	documented in part, "Oxygen cannula." ade of Resident #31 on nately 12:06 p.m. The resident ygen on via a nasal cannula [a nat inserts into the nose] that in oxygen concentrator. The or flow meter was observed wall set on the 2.0 LPM (liters of the bottom of the ball on the ond observation was made on 14 p.m. and the oxygen was the first observation. ade of Resident #31 on in her bed with her oxygen incentrator flow meter was op of the ball set on the 2.0 ute) line and the bottom of the line. Inducted with LPN (licensed on 7/17/19 at 3:22 p.m. LPN serve the oxygen concentrator #31. When asked what flow is set at, LPN #3 stated it was per minute). When asked how	F6	95	DEFICIENCY)		8-29-19
	to the physician pre-	on the oxygen concentrator scribed rate, LPN #3 stated, has to be on the prescribed					
	nurse) #6, the interiors 3:30 p.m. When ask oxygen concentrato RN #6 stated, "You	inducted with RN (registered m unit manager, on 7/17/19 at ked how the flowmeter on the r is set to the prescribed rate, get at eye level and the top of the prescribed line."					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		
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F 695	staff member (ASN director of nursing, asked how the staff the oxygen concern line of the prescribe center of the ball." The facility policy, "documented in part 3. For oxygen concerturn unit on and serrate." The manufacturer's part, "To properly represcribed flowrate turn the flow knob to Now, center the bath According to Funda Potter, 6th edition, treated as a drug, such as atelectasis any drug, the dosay should be continuous should routinely cheverify that the client oxygen concentration administration." Administrative staff administrator, ASM of nursing, and and and and and and and and and and	conducted with administrative (1) #2, the administrative on 7/17/19 at 4:50 p.m. When it read the oxygen flowmeter on trator, ASM #2 stated, "The ed rate has to go through the od rate has to go through the od rate has to go through the od rate has to go through the od rate has to go through the od rate has to go through the od rate has to go through the od rate has to go through the od rate has to go through the od rate has to go through the or correct flow of the flowmeter, locate the line on the flowmeter, locate the line on the LPM line prescribed." If amentals of Nursing, Perry and page 1122, Oxygen should be let has dangerous side effects, or oxygen toxicity. As with go or concentration of oxygen usly monitored. The nurse eck the physician's orders to its receiving the prescribed on. The six rights of that it is the administrative director of the adm	F6	395		20	8-29-15

PRINTED: 07/30/2019 FORM APPROVED OMB NO. 0938-0391

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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	C 07/18/2019	

Chapman, page 556.
F 697 Pain Management
SS=D CFR(s): 483.25(k)

§483.25(k) Pain Management.

The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

This REQUIREMENT is not met as evidenced by:

Non-Medical Reader, 5th edition, Rothenberg and

Based on resident interview, staff interview and clinical record review, it was determined that facility staff failed to provide pain management program consistent with professional standards of practice, and the comprehensive person-centered care plan for one of 54 residents in the survey sample, Resident # 59.

The facility staff failed to implement non-pharmacological interventions prior to the administration of as needed pain medication to Resident #59

The findings include:

Resident # 59 was admitted to the facility on 4/7/2017 with a readmission on 4/26/2019, with diagnoses that included but were not limited to chronic obstructive pulmonary disease (1), malignant neoplasm of unspecified part of unspecified bronchus or lung (2) and anxiety disorder (3).

F 697

F -- 697

8-29-17

The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated

it is the intended practice of the facility to ensure that non-pharmacological intervention is provided prior to administration of PRN pain medication.

- 1. Upon notification of surveyor on 7-18-19, administrative nursing staff were re-educated on the use of non-pharmacological interventions for pain management.
- 2. Residents that are ordered PRN pain medication and reside in the facility have the potential to be affected.
- 3. Director of Nursing and/or designee to reeducate Licensed

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	0		SURVEY PLETED
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	PROVIDER OR SUPPLIER CARE HEALTH SERVI			171	REET ADDRESS, CITY, STATE, ZIP CODE 9 BELLEVUE AVENUE CHMOND, VA 23227	<u> </u>	<i>071</i>	18/2019
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	Resident # 59's moset), a quarterly ass (assessment refere Resident # 59 as so assessment for me of 0 - 15, 15- being daily decisions. Seas having pain frequency on 07/16/19 at 2:38 conducted with Resident # 59 state on the comprehensive dated 06/01/2018 do not pain medication malignant neoplasm 06/01/2018. Revision The POS (physician "07/18/2019" for Resident # 59 state of the comprehensive dated 06/01/2018. Revision The POS (physician "07/18/2019" for Resident # 59 state of the position	st recent MDS (minimum data sessment with an ARD nce date) of 06/18/19, coded coring a 15 on the staff ntal status (BIMS) of a score cognitively intact for making ction J coded Resident # 59 uently. 8 p.m., an interview was ident # 59. When asked if the n before giving him an as sation Resident # 59 stated, y pain is and ask me a ked if the staff try to alleviate ninistering the pain medication d, "No." I care plan for Resident # 59 occumented, "The resident is Therapy r/t (related to) of lung." Date Initiated on on: 12/11/2018." Under	F	597	Nurses on the pal process and non-pharmacological interventions are provided prior to administration of pain medication. 4. The Director of N and/or designee audit medication administration re and documentative residents to reflex use of non-pharmacological intervention prior giving PRN pain medication dally days and then 3 week x 3 weeks at then monthly x 3 months. The resident the random audit be reported to the Committee for reand follow up recommendation indicated. 5. The facility's alled date of compiliar be August 29, 20	the FPRN Jursing will scord Jon of 5 ect the or to x 5 days a and cults of its will he QAA eview as as ged hee will		8-29-12

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 697	mg by mouth every Start Date: 4/26/20 Review of the eMAI was administered of time: On 07/02/19 at 04:32:49 (10:49 p.m.), 07/03/19 at 05:22 (07/04/19 at 21:146 (07/05/19 at 21:12 (07/06/19 at 05:09 (07/07/19 at 05:09 (07/07/19 at 05:08 (p.m.), 07/10/19 at 05:00 (p.m.), 07/10/19 at 05:17 (p.m.), 07/12/19 at 05:17 (p.m.), 07/12/19 at 05:17 (p.m.), 07/13/19 at 05:17 (p.m.), 07/13/19 at 05:28 (07/15/19 at 05:28 (07/15/19 at 05:26 (5.7/16/19 at 05:42 (5.7/16/19 at 05:42 (5.7/17/19 at 05:	6 hours as needed for pain. 19." R revealed Roxicodone 5mg on the following dates and 37 (4:37 a.m.), 12:20 p.m., and 5:22 a.m.), 9:46 p.m.), 9:12 p.m.), 5:09 a.m.), 4:54 a.m.), 1 (5:11 a.m.) and 21:26 (9:26 5:08 a.m.) and 20:45 (8:45 5:00 a.m.), 13:09 (1:09 p.m.) n.), 5:17 a.m.) and 21:38 (9:38 5:10 a.m.) and 20:55 (8:55 5:17 a.m.) 12:53 p.m. and 5:28 a.m.) and 12:38 p.m., 5:15 a.m.), 20 a.m.) and 21:54 (9:54 5:45 a.m.) and 22:15 (10:15 5:42 a.m.). e eMAR dated "Jul (July) R notes dated 07/01/19	F	597			8-29-11
	documentation of n	on-pharmacological o the administration of				:	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 697	conducted with RN was asked to descr administration of pr stated, "We ask wh (one) to 10 (ten), we nonverbal, and che administration recording positioning, get the visual imaging befor documentation of transcribed interventions, RN # documented when a (medication)." On 7/18/19 at 12:57 conducted with RN asked to describe the administration of prestated, "We ask whoffer non-pharmacowere not successful have, check the MA record) and the drug care plan-interventions RN #3 note with pain site a non-pharmacological of the eMAR notes a 2019, RN #3 agreed interventions were retime documented all have been told to try interventions before when you write a present time documented and the plans of the eman you write a present administration of the interventions before when you write a present administration of the eman you write a present administration of the eman told to try interventions before when you write a present administration of the eman told to try interventions before when you write a present administration of the eman told to try interventions before when you write a present administration of the eman told to try interventions before when you write a present administration of the eman told to try interventions before when you write a present administration of the eman told to try interventions before when you write a present administration of the eman told told the present administration of the eman told the present administration of the eman told the present administration of the eman told the present administration of the eman told the present administration of the eman told the present administration of the eman told the present administration of the eman told the present administration of the eman told the present administration of the eman told the present administration of the eman told the present administration of the eman told the present administration of the eman told the present administration of the eman told the present administration of the eman told the present administration of the eman to	(registered nurse) # 2. RN #2 libe the procedure for the n pain medication. RN # 2 ere the pain is, on a scale of 1 e use other pain scales if ck the MAR (medication rd). We offer other things, out of the room, music, or re meds." When asked about the non-pharmacological 2 stated, "It is usually giving a prn (as needed) med reprocedure for the n pain medication RN #3 at the pain level is, where it is, alogical interventions, if they I then look to see what they are for pain relief and see if d." When asked about the non-pharmacological interventions." After review for Resident #59 dated July at that non-pharmacological interventions." After review for Resident #59 dated July at that non-pharmacological interventions. After review for Resident #59 dated July at that non-pharmacological interventions, typically or the process of the pain relief and see in that we tried other all interventions. After review for Resident #59 dated July at that non-pharmacological meds (medications), typically or press note there is a box to ore you give meds. If it is not to the pain red is a box to ore you give meds. If it is not the pain red in the pain led in the pa	F 69			8-29-19

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING				C 1 8/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-IMPERIAL		17	FREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE ICHMOND, VA 23227		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X6) COMPLETION DATE
F 697	documented, "Phan Non-Pharmacologic include non-pharm pharmacologic. No used as initial interneed for medicatio lowest dose or resimedication." Phas "Pain Practice Guidinterdisciplinary teaplan to focus on all including those assinguardian is include build on past succeasked for suggestic have successfully uplan." On 07/18/19 at approximate (administrator) and were made aware. No further informate Reference: 1. Chronic obstruct (COPD) Disease that make lead to shortness of obtained from the whittps://www.nlm.nit.	"Pain Practice Guide" se 3: Implement (Cont.). ic Interventions- Interventions acologic as well as on-pharmacologic approaches ventions can minimize the ns, permit the use of the ult in discontinuation of e 2: Plan of the facility's policy de" documented, "The am designs the patient's care of the patient's issues esociated with pain symptoms. Interview and family or legal of the maintain consistency and esses. Caregivers are also ons about interventions they used in managing a patient's proximately 4:40 p.m., ASM # 1 ASM # 2 (director of nursing) of the findings. Ition was provided prior to exit. It difficult to breath that can of breath. This information was website: n.gov/medlineplus/copd.html.	F 6	i97			8-29-19

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/30/2019 **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 495283 B. WING 07/18/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1719 BELLEVUE AVENUE** MANORCARE HEALTH SERVICES-IMPERIAL RICHMOND, VA 23227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) B- 51-12 F 697 Continued From page 125 F 697 other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. . This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm. 3. Anxiety Fear. This information was obtained from the https://www.nim.nih.gov/medlineplus/anxiety.html #summarv. 4. Roxicodone Oxycodone-acetaminophen is used to relieve

Oxycodone-acetaminophen is used to relieve moderate to severe pain. Oxycodone extended-release tablets and extended-release capsules are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

Nurse Aide Peform Review-12 hr/yr In-Service

§483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(a).

F 730

F - 730

The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies

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

CFR(s): 483.35(d)(7)

F 730

SS=D

Event ID: U0F411

Facility ID: VA0154

If continuation sheet Page 126 of 142

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		COMPLETED			
		495283	B. WING				C /18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-IMPERIAL		17	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE ICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	This REQUIREMEI by: Based on staff intereview it was determated to ensure that nursing assistant) is required 12 hours of the findings included on 07/18/19, a reviannual trainings of revealed the following had no evidence of CNA # 3 - had no etraining and CNA # hours of annual training and CNA # hours of annual training and CNA # and the training the for CNAs # 2, #3 are about the 12 hours stated, "We check the quarterly to make so if they are short the in-house in-services." On 07/18/19 at app (administrative staff administrator, and A were made aware of the content o	NT is not met as evidenced riview and employee record mined that the facility staff it three of ten CNA (certified ecords reviewed received the of annual trainings. e: ew was conducted of the ten CNAs. This review ng missing data: CNA # 2 - 12 hours of annual training, vidence of 12 hours of annual 4 - had no evidence of 12 ining. D.p.m., an interview was M (other staff member) # 5, esources from a sister facility. facility's training hour's sheets and #4, OSM # 5 was asked of required training. OSM # 5 the progress of CNAs ure the training is on track and y should be completing the s." roximately 5:00 p.m., ASM member) #1, the ASM #2, director of nursing, of the above findings.		730	cited have been or will be corrected by the date or dates indicated It is the intended practice of the facility to ensure that every nurse aide completes 12 hours of in-services per year. 1. Upon notification from surveyor on 7-18-19, administration staff were educated on the need for 12 hours of in-services for CNA staff per year. 2. Aides who are employed in the facility have the potential to be affected. 3. Administrator and/or designee to re-educate Administration staff and nursing staff educated on the need of 12 hours of inservice training per year. 4. Human Resources Director and/or designee to audit employee files for inservices daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be August 29, 2019.		8-29-19
F 761 SS=D	Label/Store Drugs a CFR(s): 483.45(g)(l	and Biologicais n)(1)(2)	F 7	761	The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To		3-29-19

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED			
		495283	B. WING				C /18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-IMPERIAL		1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 761	§483.45(g) Labeling Drugs and biological labeled in accordary professional principappropriate access instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In acceptal laws, the febiologicals in locke temperature contropersonnel to have set to be comprehensive Control Act of 1976 abuse, except when package drug districtly detected This REQUIREMENT by: Based on observated that the expired medications we of two facility medications were the comprehensive control and medications were two facility medications were two facility medications were the comprehensive control and medications were two facility medications were the comprehensive control and medications were two facility medications were the comprehensive control and medications were the comprehensive control and medications were the comprehensive control and medications were the comprehensive control and medications were the comprehensive control and medications were the comprehensive control and medications were the comprehensive control and medications were the comprehensive control and medications were the comprehensive control and medications were the comprehensive control and medications were the comprehensive control and medications were the comprehensive control and medications were the comprehensive control and medications were the comprehensive control and control	g of Drugs and Biologicals als used in the facility must be not with currently accepted oles, and include the ory and cautionary e expiration date when of Drugs and Biologicals accidity must store all drugs and documpartments under proper access to the keys. facility must provide separately yaffixed compartments for addrugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to a the facility uses single unit bution systems in which the animal and a missing dose can of the proper access to the description of the facility uses single unit bution systems in which the animal and a missing dose can of accidity staff failed to ensure a were not available for use are dated when opened in one cations rooms, (Unit 1 and in two of three facility observed on Unit 2, 3 and #2).		761	remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated it is the intended practice of this facility to ensure that the labeling of drugs and biologicals drugs used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 1. Upon notification of surveyor the insulin vial was disposed of properly on 7-18-19. 2. Residents who have been prescribed insulin have the potential to be affected. 3. Director of Nursing and/or designee to re-educate licensed nursing staff on proper labeling procedures for drugs and biologicals drugs used in the facility. 4. Director of Nursing and/or designee to audit medication carts and medication carts and medication rooms daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.		8-29-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l''		LE CONSTRUCTION	COMPLETED COMPLETED		
		495283	B. WING			07/	18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	ICES-IMPERIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	Continued From pa 1. An open 3 millili without an open da Unit 1 medication r On 07/18/19 at 10: facility's medicatior conducted with RN unit manager. Obs the Unit 1 medicati open 3 milliliter vile open date and ava observation of the vile documented, " The vile failed to ev was asked to obse identify the date wi unable to locate the about the missing of have been dated" ovile of Humalog from HUMALOG is a ray indicated to improve and children with of have been opened refrigerator or at ro (30°C) for up to 28 heat and out of dire	age 128 Iter vile of Humalog (1) insuling the was available for use in the room. 30 a.m., an observation of the instorage room on Unit 1 was a (registered nurse) # 4, interiming servation of the refrigerator in son storage room revealed an erof Humalog insulin without an illable for use. Further vile of Humalog revealed the Discard 28 days after opening." Vidence an open date. RN # 4 was eropen date. When asked date, RN # 4 stated, "It should and immediately removed the orm the medication storage opid acting human insulin analogical procession of the promoted in the	F	761	DEFICIENCY)	of	8-29-19
	(administrative stated administrator, and	proximately 5:00 p.m., ASM ff member) #1, the ASM #2, director of nursing, of the above findings.					
	No further informa	tion was provided prior to exit.					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495283	B. WING	i		l	18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-IMPERIAL		1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	, 0.7	
(X4) ID PRÉFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	to improve glycemi with diabetes melliful obtained from the white https://dailymed.nlm?setid=c8ecbd7a. 2. Medication cart with an open bottle expiration date of resident use and a strips with an expir was was available On 07/18/19 at 10: 2 medication cart from the companient of the opened bottle of the opened bottle of sexpiration date of use and a bottle of an expiration date of use and a bottle of an expiration date of the when shown the bear remove When asked how concert is checked to pharmacy."	uman insulin analog indicated c control in adults and children tus. This information was website: n.nih.gov/dailymed/druglnfo.cf a-0e22-4fc7-a503-faa58c1b6f3f # 3 on Unit 2 was observed of Fish Oil soft gel with an 05/19" that was available for bottle of 24 PT/INR (1) test ation date of "2019-05-31" that for use. 55 a.m., an observation of Unit 3 was conducted with RN # 3, RN supervisor. medication cart reveled and oil soft gels with an 05/19" available for resident 24 PT/INR (2) test strips with of "2019-05-31" available for drawer of the medication cart. ottle of fish oil and the bottle of RN # 3 stated they should deform the medication carts are ditems, RN # 3 stated, "The rotimes a week by nursing and	F	761	DEFICIENCY		8-29-19
	(administrative staf administrator, and	proximately 5:00 p.m., ASM f member) #1, the ASM #2, director of nursing, of the above findings.	i.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/30/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495283 **B. WING** 07/18/2019 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 (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X6) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 8-29-19 F 761 Continued From page 130 F 761 No further information was provided prior to exit. References: (1) PT - A blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot. This information was obtained from the website: https://medlineplus.gov/ency/article/003652.htm. International normalized ratio (INR) is the preferred test of choice for patients taking vitamin K antagonists (VKA). It can also be used to assess the risk of bleeding or the coagulation status of the patients. Patients taking oral anticoagulants are required to monitor INR to adjust the VKA doses because these vary between patients. The INR is derived from prothrombin time (PT) which is calculated as a ratio of the patient's PT to a control PT standardized for the potency of the thromboplastin reagent developed by the World Health Organization (WHO) using the following formula: This information was obtained from the website: https://www.ncbi.nlm.nih.gov/books/NBK507707/. 3. An open 10 milliliter bottle of Azopt eye drops (3) without an open date was observed opened and available for use in medication cart # 2 on Unit 2. On 07/18/19 at 11:05 a.m., an observation of Unit 2 medication cart # 2 was conducted with RN

(registered nurse) # 2. Observation of the medication care reveled an opened 10 milliliter bottle of Azopt eye drops without an open date. When shown the bottle of Azopt eye drops, RN # 2 stated it she didn't know how long it had been opened and it should have an open date on it. RN #2 removed the bottle of Azopt eye drops from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495283	B. WING			18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
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F 761	(administrative state administrator, and were made aware No further informat References: (1) Ophthalmic Briglaucoma, a condit the eye and leads in a class of medic anhydrase inhibito the eye. This inform website: https://medlineplustml Food Procurement CFR(s): 483.60(i)(§483.60(i) Food sa The facility must - §483.60(i)(1) - Pro approved or considerate or local author (i) This may include from local produce and local faws or ref (ii) This provision of the contract of the co	proximately 5:00 p.m., ASM if member) #1, the ASM #2, director of nursing, of the above findings. Ition was provided prior to exit. Interpretation that increases pressure in the vision loss. Brinzolamide is ations called carbonic rs. It decreases the pressure in mation was obtained from the segov/druginfo/meds/a601233.h (Store/Prepare/Serve-Sanitary 1)(2) Interpretation sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities. Interpretation of the sources dered satisfactory by federal, porities.	F 7		o and vithin in. To ieral has vith in n n of	8-29-19
	gardens, subject to safe growing and f (iii) This provision	acilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.		It is the intended practice of the fa to store and prepare food in accord with professional standards of fo service safety.	ance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	1	495283	B. WING	ــــــا ا			C 18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	ICES-IMPERIAL		17	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227		
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F 812	serve food in accor standards for food a This REQUIREMENT by: Based on observat document review it facility staff failed to sanitary manner, in The findings included an an open elevanilla icing and an chocolate icing. On 07/16/19 11:58 facility's kitchen was staff member) # 6, Observation of the eleven pound container of vanilla of 07/10/19 on the I container of chocolate icing was open container of the top that it had already be the lid back onto the icing smeared onto stated he wanted to dry storage room wicing. When OSM in of chocolate icing C	re, prepare, distribute and rdance with professional service safety. NT is not met as evidenced ation, staff interview, and facility the was determined that the constore and serve food in a contract that the facility kitchen. It failed to document an open deven-pound container of the eleven-pound container of the conducted with OSM (other	F	812	1. Upon notification of surveyor on 7-16-19, food service director disposed of the improperly labeled icing and pureed fruit. Food service director also removed pans, ple servers and basting brush that had food debris and grease on them. 2. Residents that reside in the facility have the potential to be affected. 3. Food service director and/or designee to educate Dietary staff on safe and sanitary practices. 4. Food Service Director and/or designee will audit food service area for improperly labeled items as well as improperly stored pans/utensils. Food Service Director and/or designee will audit food services staff on safe sanitary practices to include labeling opened items and properly cleaning/storing pans and utensils daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compilance will be August 29, 2019.		8-29-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED			
		495283	B. WING			1	C /18/2019
	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY 1719 BELLEVUE AVER RICHMOND, VA 232	NUE	1 011	110/2019
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F 812	chocolate icing. 2. The facility staff pureed fruit while the refrigerator to preve cross-contamination. Upon entering the wat approximately 11 containing two sheet taken out of the wall pan contained four other sheet pan confruit. Further observation of the containing two sheet pan was covered as the facility staff pans were not wet in the facility's pans stacked wet, the containing brush. On 07/17/19 at 2:58 conducted with OSN When asked to describe as the containing brush. On 07/17/19 at 2:58 conducted with OSN When asked to describe as the containing brush. On 07/17/19 at 2:58 conducted with OSN When asked to describe as the containing brush. On 07/17/19 at 2:58 conducted with OSN When asked to describe as the containing brush.	failed to cover nine plates of they were stored in the walk-in ent potential in. valk-in refrigerator on 07/16/19 :58 a.m., a ladder rack est pans of pureed fruit was k-in refrigerator. One sheet plates of pureed fruit and the stained five plates of pureed vation revealed that neither ered. failed to ensure clean shallow nesting. roximately 12:30 p.m., an lean storage rack of pots and kitchen revealed five half wo half pans with food debris ated hotel pan with food	F				8-29-15

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495263	B. WING		07	C 07/18/2019	
	PROVIDER OR SUPPLIEF CARE HEALTH SERV	/ICES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 0/	710/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 842 SS=D	6 stated, "We try to before they are starnelted due to use inspected before hasked why it was i while they were stididn't have food de "To prevent any be Regarding the purshould have been stated, "Any food when it is stored time. The facility's policy Marking" documer following delivery, identify the item are temperature inform. The facility's policy and Pans" docume from sanitizing sint Pans may be stack. The facility's policy documented, "1. Stremove debris and On 07/17/19 at app (administrative stated administrative sta	c ensure they are air dried acked. The basting brush was so it was discarded. They are being air dried." OSM #6 was important not to stack pans all wet, and to make sure they be bris on them. OSM #6 stated, acteria from growing inside." Bed fruit, OSM # 6 stated they covered. OSM # 6 further product should be covered in the refrigerator." "Labeling Food and Date atted, "Foods are labeled preparation or opening to ad to provide date, time and or mation." "Cleaning Procedure - Pots anted. "Guidelines. 7. Remove action." "Manual Ware Washing" are once completely dry." "Manual Ware Washing" are provided prior to be washed." Proximately 4:50 p.m., ASM frommber) #1, the ASM #2, director of nursing, of the above findings. In was provided prior to exit.	F 84	F – 842 The statements made on this properties of the alleged deficiencies cited here remain in compliance with all feand state regulations, the center taken or will take the actions set the following plan of correctic constitutes the center's allegatic compliance. All alleged deficiencited have been or will be correct the date or dates indicated it is the intended practice of the fit to maintain a complete and accuration constitutes the center's allegatic compliance. All alleged deficiencited have been or will be correct the date or dates indicated it is the intended practice of the fit to maintain a complete and accurations accurately constitutes the cord. 1. Upon notification of surveyor on 7-18-19 administrative numbers.	o and vithin vin. To ileral r has orth in n n of cles ed by clity rate f he staff n clical s.	8-29-19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DESICIENCIES (XX) PROVIDER/SUBBLIEB/OLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			NG	COMPLETED	
		495283	B. WING		C 07/18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-IMPERIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	
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F 842	resident-identifiable (ii) The facility may resident-identifiable accordance with a agrees not to use of except to the extert to do so. §483.70(i) Medical §483.70(i)(1) In accordent in the professional stands must maintain meditat are- (i) Complete; (ii) Accurately docution (iii) Readily access (iv) Systematically §483.70(i)(2) The fall information contregardless of the forecords, except who (i) To the individual representative who (ii) Required by Law (iii) For treatment, operations, as permith 45 CFR 164.5 (iv) For public healineglect, or domest activities, judicial a law enforcement proposes, research medical examiners a serious threat to	at release information that is to the public. It release information that is to an agent only in contract under which the agent or disclose the information at the facility itself is permitted records. It is permitted records and practices, the facility dical records on each resident records and practices, the facility dical records on each resident remember and organized records acility must keep confidential tained in the resident's records, orm or storage method of the release is, or their resident records acility must be permitted by applicable law; w; payment, or health care mitted by and in compliance		have the potential to be affected. 3. Director of Nursing and/or designee to educate Licensed nursing on the Falls Practice Guide. 4. Director of Nursing and/or designee will complete audits of falls daily x 5 day; and then 3 days a week x 3 weeks and then monthly x months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date compliance will be August 29, 2019.	s 3 2

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		TE SURVEY MPLETED
		495283	B. WING _		07	C /18/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	<u> </u>	710/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	§483.70(i)(3) The farecord information a unauthorized use. §483.70(i)(4) Medic for- (i) The period of tim (ii) Five years from there is no requirem (iii) For a minor, 3 y legal age under State §483.70(i)(5) The minor (ii) A record of the minor (iii) The comprehen provided; (iv) The results of an and resident review determinations cond (v) Physician's, nursiprofessional's progrivi) Laboratory, radius services reports as This REQUIREMEN by: Based on staff internated clinical record in the facility staff falled accurate clinical record the survey sample, I The findings include	acility must safeguard medical against loss, destruction, or all records must be retained be required by State law; or the date of discharge when nent in State law; or ears after a resident reaches te law. Inedical record must containation to identify the resident; esident's assessments; sive plan of care and services my preadmission screening evaluations and ducted by the State; se's, and other licensed ess notes; and ology and other diagnostic required under §483.50. IT is not met as evidenced eview, facility document review eview, it was determined that d to maintain a complete and ord for one of 54 residents in Resident #79.	F 84			8-29-19
!	tacility staff failed to	document information Resident #79's clinical record.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/30/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED C 495283 B. WING 07/18/2019 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 (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) X-29-L1 F 842 Continued From page 137 F 842 Resident #79 was admitted to the facility on 7/31/14. Resident #79's diagnoses included but were not limited to stroke, high blood pressure and insomnia (difficulty sleeping). Resident #79's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/2/19, coded the resident's cognition as moderately impaired. Review of a fall investigation revealed Resident #79 slid out of the bed on 2/21/19. Review of Resident #79's clinical record failed to reveal any information regarding the fall. On 7/18/19 at 10:41 a.m., an interview was conducted with RN (registered nurse) #3. RN #3 was asked if a fall should be documented in a resident's clinical record. RN #3 stated, "Yes." When asked why, RN #3 stated, "So that everyone is aware the patient had a fall. In case F-880 there is a change in neurological status or hip

FORM CMS-2587(02-99) Previous Versions Obsolete

F 880

SS=D

pain. So everyone will know."

resident's clinical record.

Infection Prevention & Control

CFR(s): 483.80(a)(1)(2)(4)(e)(f)

fall documentation.

On 7/18/19 at 11:55 a.m., ASM (administrative

(the administrative director of nursing) and ASM

#3 (the quality assurance consultant) were made

aware of the above concern. ASM #1 and ASM

#2 confirmed fall investigations are not part of a

The facility documented titled, "Falls Practice

Guide" failed to document information regarding

No further information was presented prior to exit.

staff member) #1 (the administrator), ASM #2

Event ID: U0F411

Facility ID: VA0154

F 880

If continuation sheet Page 138 of 142

-29-19

The statements made on this plan of

correction are not an admission to and

do not constitute an agreement within

the alleged deficiencles cited herein. To

remain in compliance with all federal

and state regulations, the center has

taken or will take the actions set forth in

the following plan of correction

constitutes the center's allegation of

compliance. All alleged deficiencies cited have been or will be corrected by

the date or dates indicated

It is the intended practice of the facility

to establish and maintain an infection prevention and control program

designed to provide a safe, sanitary,

and comfortable environment, and to

help prevent the development and

transmission of communicable diseases and infections.

AND PLAN OF CORRECTION IDENTI		IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		495283	B. WING				C /18/2019	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-IMPERIAL				1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227			
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ļ	§483.80 Infection Control facility must est infection prevention designed to provide comfortable enviror development and tradiseases and infect §483.80(a) Infection program. The facility must est and control program a minimum, the following services us arrangement based conducted according services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff, volunteers, vis providing services us arrangement based conducted accordinaccepted national staff	control tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable ions. In prevention and control tablish an infection prevention In (IPCP) that must include, at owing elements: tem for preventing, identifying, ing, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment 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 ey; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a	F	380	 Upon notification of surveyor on 7 17-19, Nurse was re-educated by the nurse supervisor on the non- sterile wound care process to include cleaning the scissors prior to placing them on a clean barrier. Residents who reside in the facilit have the potential to be affected. Director of Nursing and/or designe to re-educate Licensed Nurses or infection control practices during wound care including cleaning scissors prior to placing them on	y y dee d d d	8-29-19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER SUPPLIER 495283 (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVE COMPLETED (X4) ID	FORM APPROVED OMB NO. 0938-0391			& MEDICAID SERVICES	RS FOR MEDICARE	CENTER
MANORCARE HEALTH SERVICES-IMPERIAL STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 139 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (V) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will residents or their food, if direct contact will resident or their food, if direct contact will resident or their food, if direct contact will resident or their food, if direct contact will resident or their food, if direct contact will resident or their food will resident or their food will resident or their food will resident or the	INSTRUCTION (X3) DATE SURVEY			(X1) PROVIDER/SUPPLIER/CLIA	OF DEFICIENCIES	STATEMENT
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F 880 Continued From page 139 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct residents contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	BELLEVUE AVENUE	1719			CARE HEALTH SERVI	
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	(EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DATE		PREF	/ MUST BE PRECEDED BY FULL	EACH DEFICIENCY	PREFIX
transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that facility staff failed to implement infection control practices during a dressing change to prevent the spread or development of infection for one of 54 residents in the survey sample, Residents # 37. The finding include: Resident # 37 was admitted to the facility on	8-29-19	380	F	uration of the isolation, a infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact. Item for recording incidents facility's IPCP and the taken by the facility. Indie, store, process, and taken by the facility. Indie, store, process, and taken by the series of the spread of the eview. If it is not met as evidenced the information of the store of the st	(A) The type and dudepending upon the involved, and (B) A requirement the least restrictive poscircumstances. (v) The circumstance must prohibit emploid disease or infected contact with resider contact will transmit (vi)The hand hygien by staff involved in contact with resider contact will transmit (vi)The hand hygien by staff involved in contact with resider contact with resider contact with resider contact with resider to the corrective actions to \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must hand transport linens so a infection. §483.80(f) Annual residention. §483.80(f) Annual residention. §483.80(f) Annual residention on observation record review and fadetermined that facilinfection control practical control practical properties of the finding include:	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/30/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-IMPERIAL			171	REET ADDRESS, CITY, STATE, ZIP CODE 9 BELLEVUE AVENUE CHMOND, VA 23227		/18/2019	
PREFIX (EACH	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)			D BE	(X5) COMPLETION DATE
diagnoses peripheral and hyperal and hyperal and hyperal set), a qual (assessming resident interview inter	and a re-ast that included in vascular reference and a re-ast tension (in tens	admission on 11/16/18 with uded but were not limited to: disease (1), dysphagia (2), 3). Instrecent MDS (minimum data sessment with an ARD once date) of 05/27/19, coded coring a three on the brief I status (BIMS) of a score of 0 severely impaired of cognition cisions. In p.m., an observation of using change was observed, and RN (registered nurse) # served removing a pair of useatment cart and placing them RN # 6 set up a clean barrier table and LPN # 5 placed all ons and scissors on the clean servation failed to evidence us scissors prior to placing parrier. Using the scissors are treatment cart, LPN # 5 skage of cling wrap and used it sident # 37's ankle after she up adsover the wound. Using LPN #5 cut the medical tape ne cling wrap to hold the p.m., an interview was I # 5. When asked about the scissors with the antibiotic wine dissors with the dissors with the dissors with the antibiotic wine distoration and the dissors with the dissors with the distoration and the distor	F	380			8-29-19

AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
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F (b) cAcvyboha (30hs) (30hs)	administrative staff administrator, and A vere made aware of the formation of the following and the following and the following and the following discount of the following di	roximately 5:00 p.m., ASM member) #1, the ASM #2, director of nursing, of the above findings. on was provided prior to exit. stem is the body's network of ludes the arteries, veins and or blood to and from the heart. This information was rebsite: .gov/medlineplus/vasculardise order. This information was ebsite: .gov/medlineplus/swallowingdiesure. This information was	F8	880			8-29-69