PRINTED: 06/22/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	O. 0938-03 E SURVEY PLETED
	495045	B. WING		00	(00/2020
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVI		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228	1 06	/09/2020
PREFIX (EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
Preparedness CO conducted remote facility was in substant Part 483.73, Requiracilities. F 000 INITIAL COMMEN An unannounced a Focused Survey with consiste on 6/9/2020 compliance with Federal Long Term The census in this 138. Of the current currently positive for survey sample confection Prevention CFR(s): 483.80(a)(§ 483.80 Infection CThe facility must est infection prevention designed to provide comfortable environdevelopment and tradiseases and infection program. The facility must est and control program a minimum, the follows.	abbreviated COVID-19 as conducted remotely and . Corrections are required for .880 of 42 CFR Part 483 . Care requirement(s). 194 certified bed facility was residents, zero residents were or the COVID-19 virus. The sisted of eleven current tesidents #1 through #11). a. & Control 1)(2)(4)(e)(f) Control tablish and maintain an and control program a safe, sanitary and ament and to help prevent the ansmission of communicable ions. a prevention and control (ablish an infection prevention (IPCP) that must include, at		/4) F	facility have facility have rated on clude f 6 feet apart, ation of urage 6 feet ne common t infection ppropriate v x5 days, x2 months, ed to OAPI	07/03/20

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 program participation.

6-23-26

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		F CORRECTION IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DA	NO. 0938-0391 TE SURVEY MPLETED
		495045	B. WING			6/09/2020
MANORO	ARE HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP COU 2125 HILLIARD ROAD RICHMOND, VA 23228	DE	010312020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	and communicable staff, volunteers, vis providing services us arrangement based conducted accordin accepted national si §483.80(a)(2) Writtle procedures for the pout are not limited to (i) A system of surver possible communications before the persons in the facilit (ii) When and to who communicable disease reported; (iii) Standard and tratto be followed to pre (iv)When and how is resident; including but (A) The type and dur depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstances must prohibit employ disease or infected sicontact will transmit to (vi)The hand hygiene by staff involved in disease.	ting, and controlling infections diseases for all residents, sitors, and other individuals ander a contractual upon the facility assessment g to §483.70(e) and following tandards; and standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other y; and prossible incidents of use or infections should be used for a cut not limited to: ration of the isolation, infectious agent or organism at the isolation should be the ible for the resident under the use under which the facility ees with a communicable kin lesions from direct or their food, if direct	F 880			

STATEMENT OF DEFICIENCIES		WIEDICAID SERVICES			OMB NO. 0938-0391		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED	
		495045	B. WING			6/00/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		6/09/2020	
MANORO	ADE HEALTH OFFI			2125 HILLIARD ROAD			
WANORC	ARE HEALTH SERVIC	ES-RICHMOND		RICHMOND, VA 23228			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From pa	age 2	F 88				
	corrective actions t		F 00				
	§483.80(e) Linens.						
		ndle store process and					
	Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.						
	§483.80(f) Annual r	eview.					
	The facility will cond	duct an annual review of its					
	IPCP and update th	eir program, as necessary.					
		NT is not met as evidenced					
	by:						
	Based on observat	ion, staff interview, facility					
	was determined the	nd clinical record review, it t the facility staff failed to					
		rol procedures to prevent the					
	spread of a commun	nicable disease during a					
	COVID-19 outbreak	for eleven of 11 residents in					
	the survey sample,	(Residents #1, #2, #3, #4, #5,					
	#6, #7, #8, #9, #10,	and #11). The facility failed to					
		ere at least six feet apart in the					
		non room per the CDC					
	[Center of Disease (Control] for COVID 19.					
	The findings include	:					
	with diagnoses that	mitted to the facility on 3/9/19 included but were not limited					
	to: Alzheimer's disea	ase (a progressive loss of					
	mental ability and fu	nction, often accompanied by					
		and emotional instability.)				1 1	
		high blood pressure. The					
	most recent MDS (m						
	assessment referen	erly assessment, with an ce date of 6/1/2020 coded the					
	resident as scoring a	a "7" on the BIMS (brief					
	interview for mental	status) score, indicating the					
	resident was severel	ly impaired to make daily					
		Resident #1's comprehensive					

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STATEMENT OF DEFICIENCIES		MEDICAID SERVICES			OMB I	OMB NO. 0938-0391	
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	The control of the co	TE SURVEY MPLETED	
		495045	B. WING			6/09/2020	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	ES-RICHMOND	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD	1 0	6/09/2020	
	The state of the s			RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	Continued From pa	ge 3	F 880				
	care plan dated 3/9	/19 and revised on 3/25/2020, ocumentation related to	F 880				
	10/31/16 with diagn not limited to Alzheii and osteoporosis (a causing fragile bone most recent MDS (n assessment, a quar assessment referen resident as unable to staff interview was recomprehensive care revised last on 12/2	Imitted to the facility on oses that included but were mer's disease, depression bnormal loss of bony tissue, es that fracture easily) (2). The minimum data set) terly assessment, with an oce date of 3/17/20 coded the complete the interview; the not completed. Resident #2's a plan dated 8/11/17 and 7/19, failed to evidence ed to infectious diseases or					
	1/2/17 with diagnose limited to Alzheimer' hypothyroid disease hormone to meet you Resident #3's most in set) assessment, a cassessment reference the resident was have memory problems. For care plan dated 1/10 failed to evidence do infectious diseases of Resident #4 was adm 2/16/20 with diagnos limited to: Alzheimer' diabetes. The most reset) assessment, a question of the control of the contro	ur body's needs.) (4). recent MDS (minimum data quarterly assessment, with an ce date of 4/21/2020, coded ring both short and long-term resident #3's comprehensive /17 and revised on 4/24/20, recumentation related to					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB N	IO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second secon			TE SURVEY MPLETED
	495045	B. WING		0	6/09/2020
OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		0/00/2020
ALTH SERVICE	ES-RICHMOND				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
ew for mental and was sever the decisions ehensive cand on 4/17/20 tentation relation control. The sent #5 was an owith diagnation and retain and conditions and retain and conditions are called a off for longer the second off for longer the second and longer the second and longer the second and revise entation relation control. The second was an owith diagnatic the second and longer the second and longer the second and revise entation relation control. The second was an owith diagnatic the second and longer the second and revise entation relation control.	a "5" on the BIMS (brief al status) score, indicating the rely impaired to make daily so Resident #4's are plan dated, 2/24/20 and failed to evidence ated to infectious diseases or admitted to the facility on coses that included but were not an experience of the brain stops. A stroke is a "brain attack." If blood flow than a few seconds, the brain is and oxygen. Brain cells can be damage.) (6). The most form a memory problems. The prehensive care plan dated and on 6/11/20, failed to evidence ated to infectious diseases or dimitted to the facility on coses that include but are not an depression, and anxiety. The recent MDS (minimum data quarterly assessment, with an accedate of 4/1/20, coded the recent manages.) (6). The most consistency of the prehensive care plan dated and on 6/11/20, failed to evidence ated to infectious diseases or dimitted to the facility on coses that include but are not an depression, and anxiety. The prehensive care manages are not an experience of the date of 4/1/20, coded the code of 4/1/20,	F 880			
	SUMMARY (EACH DEFICIE REGULATORY) Inued From part as scoring ew for mentant was severe ive decisions ehensive car don 4/17/20 mentation relation control. The service of	ALTH SERVICES-RICHMOND SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Auded From page 4 Int as scoring a "5" on the BIMS (brief ew for mental status) score, indicating the nt was severely impaired to make daily ive decisions. Resident #4's ehensive care plan dated, 2/24/20 and d on 4/17/20 failed to evidence inentation related to infectious diseases or on control. Bent #5 was admitted to the facility on 0 with diagnoses that included but were not 1 to dementia, congestive heart failure imal condition characterized by circulatory estion and retention of salt and water by the so (5), and stroke. (A stroke occurs when flow to a part of the brain stops. A stroke is imes called a "brain attack." If blood flow off for longer than a few seconds, the brain it get nutrients and oxygen. Brain cells can using lasting damage.) (6). The most MDS (minimum data set) assessment, a rily assessment, with an assessment ince date of 5/26/20 coded the resident with nort and long-term memory problems. But #5's comprehensive care plan dated 29 and revised on 6/11/20, failed to evidence entation related to infectious diseases or	ASSOCIATION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL A. BUILDING. 495045 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREEIX TAG THE ASSOCIATION THE BIMS (brief ew for mental status) score, indicating the nt was severely impaired to make daily ive decisions. Resident #4's ehensive care plan dated, 2/24/20 and d on 4/17/20 failed to evidence mentation related to infectious diseases or on control. Sent #5 was admitted to the facility on 0 with diagnoses that included but were not to dementia, congestive heart failure mal condition characterized by circulatory stion and retention of salt and water by the s) (5), and stroke. (A stroke occurs when flow to a part of the brain stops. A stroke is mes called a "brain attack." If blood flow off for longer than a few seconds, the brain t get nutrients and oxygen. Brain cells can using lasting damage.) (6). The most MDS (minimum data set) assessment, a rily assessment, with an assessment loce date of 5/26/20 coded the resident with hord and long-term memory problems. Int #6's comprehensive care plan dated 9 and revised on 6/11/20, failed to evidence entation related to infectious diseases or on control. Int #6 was admitted to the facility on 5 with diagnoses that include but are not to: dementia, depression, and anxiety. Int #6's most recent MDS (minimum data sessment, a quarterly assessment, with an ment reference date of 4/1/20, coded the it as severely cognitively impaired for it daily decisions. A review of Resident #6's ethensive care plan dated 4/16/20 failed to	ASTREET ADDRESS, CITY, STATE, ZIP CODE ASSUMPTION ASSUMENT STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) THE WAS SEVERELY Impaired to make daily live decisions. Resident #4's ehensive care plan dated of a "brain attack." If blood flow off for longer than a few seconds, the brain signe full miles to a part of the brain stops. A stroke is more called a "brain attack." If blood flow off for longer than a few seconds, the brain signe full miles and waspen, with an amount and long-term memory problems. Inter and long-term memory problems. Inter and long-term memory problems. Inter and a sessment, a quarterly assessment a rive damentia, cepression, and anxiety. Int #6 was admitted to the facility on the sidney of the problems. In the sidney of the problems are recently assessment and control. Int #6 was admitted to the facility on the sidney of the problems. In the sidney of the problems are recently assessment, a quarterly assessment, and the problems are recently assessment, a quarterly assessment, and anxiety, and the problems are recently assessment, and the problems are recently cognitively impaired for quarterly decisions. A review of Resident #8's ehensive care plan dated 4'16/20 failed to the problems and anxiety.	INCOMES IDENTIFICATION NUMBER 495045 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICENCY BUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREGULATORY OR LSC IDENTIFYING INFORMATION FREGULATORY OR LSC IDENTIFY INFORMATION FREGULATORY OR

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FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	TE SURVEY MPLETED
		495045	B. WING		0	6/09/2020
	ROVIDER OR SUPPLIER	CES-RICHMOND	2129	EET ADDRESS, CITY, STATE, ZIP CODE 5 HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	Resident #7 was a	age 5 Idmitted to the facility on noses that include but are not ia, diabetes mellitus (inability of	F 880			
	insulin to function failure. Resident # data set) assessm with an assessmen	in the body) (7), and kidney 7's most recent MDS (minimum ent, a quarterly assessment, nt reference date of 6/3/20,				
	the BIMS (brief into indicating the resident #7's care	as scoring a 14 out of 15 on erview for mental status), lent was cognitively intact. plan dated 5/29/20 rt, "Focus-Infection of				
	Respiratory tract wadminister medical	ith interventions including tions as ordered".				
	with diagnoses that dementia, diabetes (recurrent episodes	dmitted to the facility on 1/4/20 t include but are not limited to: mellitus, and epilepsy s of convulsive seizure) (8).				
	set) assessment, a assessment references resident as severel making daily decisi	t recent MDS (minimum data quarterly assessment, with an nice date of 5/6/20, coded the y cognitively impaired for ons. A review of Resident d 4/25/20 failed to reveal any				
	Resident #9 was as with diagnoses that dementia, kidney fa perceptions of reali	dmitted to the facility on 7/2/15 include but are not limited to: ailure, and psychosis (impaired ty) (9). Resident #9's most um data set) assessment, a				
	quarterly assessme reference date of 4, severely cognitively decisions. Resident	ent, with an assessment (6/20, coded the resident as impaired for making daily #9's care plan, dated 1/5/19, information related to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495045	B. WING	Walter and the second s	06/09/2020	
	ROVIDER OR SUPPLIER ARE HEALTH SERVI	CES-RICHMOND	2129	EET ADDRESS, CITY, STATE, ZIP COU 5 HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION	
F 880	Continued From p	page 6	F 880			
	8/22/17 with diagral limited to: dement distortions or realit contacts) (10) and recent MDS (mining quarterly assessmant reference date of severely cognitive decisions. Reside documented, "Fooleft armpit, new boileft leg and thigh. precautions as incompleted to: dement mania and depresent mellitus. Resident (minimum data seassessment, with of 4/8/20 coded the of 15 on the BIMS status) score, indimoderately cognitive decisions. Resided did not contain an control. On 6/9/20 at 10:50 on the facility's deunit, observation raround various tal Seated together a #2, and #3. They work observation reveals to the seated together a #2, and #3. They work observation reveals to the seated together a #2, and #3. They work observation reveals to the seated together a #2, and #3. They work observation reveals to the seated together a #2, and #3. They work observation reveals to the seated together a #2, and #3. They work observation reveals to the seated together a #2, and #3. They work observation reveals to the seated together a #2, and #3. They work observation reveals to the seated together a #2, and #3. They work observation reveals to the seated together a #2.	admitted to the facility on moses that include but are not ia, schizophrenia (gross ty, withdrawal from social dianxiety. Resident #10's most mum data set) assessment, a ment, with an assessment and include for making daily int #10's care plan dated 4/24/20 cas Infection of skin boil under bils to face, neck, pubic area, intervention: maintain dicated." admitted to the facility on coses that include but are not ia, bipolar disorder (episodes of ision) (11) and diabetes in #11's most recent MDS is assessment, a quarterly an assessment reference date are resident as scoring a nine out is (brief interview for mental cating the resident was ively impaired for making daily int #11's care plan dated 1/4/20 by information related to infection in the common room. It is a common room is a common room is a common room. It one table, were Residents #1, were all less than six feet apart. It is a cated together at another table is seated together at another table.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495045	B. WING		0	6/09/2020	
	ROVIDER OR SUPPLIER	CES-RICHMOND	2	FREET ADDRESS, CITY, STATE, ZIP CO 125 HILLIARD ROAD ICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	less than six feet a and #6. None of the mask. Seated togonic six feet apart were. Observation was wearing a mark #10 and #11 were six feet apart and mask. On 6/9/20 at 11:08 nurse) #1 was interviewed. Seat apart and mask. On 6/9/20 at 11:08 nurse) #1 was interviewed. Placelity came out of procedures, she with longer required to residents are required to residents were suffacilled to the residents were not room. OSM #1 states spreading the residents were suffacilled to the residents were not room. OSM #1 states and residents were not room. OSM #1 states and residents were suffacilled to the residents were not room. OSM #1 states and residents were not room.	apart, were Residents #4, #5, he residents was wearing a bether at a third table, less than a Residents #7, #8, and #9 herevealed none of the residents lask. At fourth table, Residents seated. They were less than were not observed wearing a sa.m., LPN (licensed practical erviewed. When asked if she he dementia unit, she stated last if residents usually wear lare out of their room or in a last last when the first phase of COVID-19 has told the residents were no wear masks. When asked if lired to be six feet apart at all lated, "Yes they are." When last last each great a part, LPN #1 stated, we. They are not six feet apart." It is important for residents to apart, LPN #1 stated, "The last." OSM (other staff lementia unit activities director, one stated she was aware that oposed to remain six feet apart #1 stated she realized the last feet apart in the common ted she was "working on"	F 880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495045	B. WING			6/09/2020	
	ROVIDER OR SUPPLIER	CES-RICHMOND	21	REET ADDRESS, CITY, STATE, ZIP COD 25 HILLIARD ROAD CHMOND, VA 23228	E		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	asked if residents currently participa stated the resident distant," activities. "socially distant," residents remaine When informed of dementia unit conthey are roommat table." When aske residents observe roommates, ASM ASM #2 stated, "Noommates. They there." A review of the fact Memory Care Unit revealed, in part: to prevent the spricallenging to important are very important Try to keep their econsistent as possassisting with frequistancingContinactivities, which mactivities, which mactivities, which mactivities, which mactivities, which mactivities are sidents a feasible when in a also the wording in Control) guidance	sing, were interviewed. When in the dementia unit were ting in group activities, ASM #2 ts participate in "socially When asked the definition of ASM #2 stated this meant d six feet apart at all times. The observation in the amon area, ASM #2 stated, "If es, they are okay to share a sed to verify that any of the d at the same tables were #2 checked the resident roster. To. None of them are have really struggled back stillity policy, "Consideration for ts in Long Term Care Facilities," Infection prevention strategies and of COVID-19 are especially element in dedicated memory numerous residents with dementia. In the reside togetherRoutines a for residents with dementia. In the residents with demential and hygiene, social nue to provide structured that hand hygiene, social the day to maintain social the number of residents, or the least 6 feet apart as much as a common area." This policy is in the CDC (Centers for Disease found at ov/coronavirus/2019-ncov/hcp/	F 880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI MAPED		(X2) MULTIPLE CONSTRUCTION A. BUILDING	
		495045	B. WING		06/09/2020
	ROVIDER OR SUPPLIER	CES-RICHMOND	2125	ET ADDRESS, CITY, STATE, ZIP CODE HILLIARD ROAD HMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 880	Continued From p	page 9	F 880		
	No further informa	ation was provided prior to exit.			
	(Centers for Media which describes in practiced in long to dining limited (for asymptomatic res- eat in the same ro- (limited number of by at least 6 feet).	rmation is found in CMS care/Medicaid) memo 20-30, measures currently to be erm care facilities: "Communal COVID-19 negative or idents only), but residents may som with social distancing of people at tables and spaced." The link to this document is gov/files/document/qso-20-30-n			
	REFERENCES				
	found in many diffincluding camels, of coronavirus ide outbreak of respir detected in Wuha SARSCoV-2. (For 2019-nCoV.) The SARS-CoV-2 has information was o	s are a large family of viruses ferent species of animals, cattle, and bats. The new strain entified as the cause of the atory illness in people first in, China, has been named rimerly, it was referred to as disease caused by been named COVID-19." This obtained from the website: .nih.gov/health/in-the-news-coro mative-treatments			
		onary of Medical Terms, 5th org and Chapman, page 26.			
		onary of Medical Terms for the der, 5th edition, Rothenberg and 124.			
	(4) This information	on was obtained from the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A BUILDING		
	•	495045	B. WING		04	6/09/2020
	ROVIDER OR SUPPLIER ARE HEALTH SERVIO	CES-RICHMOND	212	REET ADDRESS, CITY, STATE, ZIP CODE 25 HILLIARD ROAD CHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	sm.html. (5) Barron's Diction Non-Medical React Chapman, page 1 (6) This information website: https://medlinepluston. (7) Barron's Diction Non-Medical React Chapman, page 1 (8) Barron's Diction Non-Medical React Chapman, page 1 (9) Barron's Diction Non-Medical React Chapman, page 1 (10) (2) Barron's Diction Non-Medical React Chapman, page 4 (10) (2) Barron's Diction Non-Medical React Chapman, page 4 (11) "Bipolar disorder manic-depressive a mental disorder mood, energy, act the ability to carry information is take	ih.gov/medlineplus/hypothyroidi mary of Medical Terms for the der, 5th edition, Rothenberg and 38. In was obtained from the s.gov/ency/article/000726.htm. mary of Medical Terms for the der, 5th edition, Rothenberg and 30. mary of Medical Terms for the der, 5th edition, Rothenberg and 99. mary of Medical Terms for the der, 5th edition, Rothenberg and 30. mictionary of Medical Terms for the der, 5th edition, Rothenberg and 30. mictionary of Medical Terms for deader, 5th edition, Rothenberg ge 518. der (formerly called fillness or manic depression) is that causes unusual shifts in vity levels, concentration, and out day-to-day tasks." This	F 880			