STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/18/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced abbreviated Emergency Preparedness COVID-19 Focused Survey was conducted 12/15/2020-12/18/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced abbreviated COVID-19 Focused Survey was conducted 12/15/2020-12/18/2020. Two complaints (VA00050054- Unsubstantiated without deficiency and VA00050324- Substantiated with deficiencies) were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. On 12/15/2020 the census in this 128 certified bed facility was 87. Of the 87 current residents, three residents were currently positive for the COVID-19 virus with 43 residents recovered. The survey sample consisted of one closed record review (Resident #1) and 7 current resident reviews (Residents #2 through #8).	F 000	F – 580 *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 notify the Physician of a change in condition.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580	1. Upon notification from the surveyor on December 18, 2020, resident #1's physician was notified of the change in condition and treatment. In addition to that, education was conducted with the licensed nurses by the Director of Nursing regarding notifying physicians for changes in condition.	1/15/2021

RECEIVED JAN 07 2021 VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kaitlyn Snyder | TITLE: Administrator | (X5) DATE: 1/5/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/18/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F 580	2. Residents who have a change in condition/medication have the potential to be affected. 3. Licensed nurses will be re-educated on the facility guidelines on notifying physicians of change in conditions and/or treatments. 4. Director of Nursing conducted a 100% audit of current residents for MD notification of any change of condition. Director of Nursing and/or designee will audit change in condition progress notes 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. Recommendations will be discussed and implemented as needed. 5. The facility's alleged date of compliance will be January 15, 2021.	1/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/18/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility document review and in the course of a complaint investigation, the facility staff failed to notify /consult with the physician regarding a need to alter the treatment plan for one of eight residents in the survey sample, Resident #1. The facility staff failed to notify and consult with the physician prior initiating oxygen therapy for Resident #1, prior to Resident #1's transport to a scheduled dialysis appointment on 12/8/2020. The findings include: Resident #1 no longer resided at that facility and could not be observed during the survey dates. The record was reviewed as a closed record. Resident #1 was admitted to the facility with diagnoses that included but were not limited to end stage renal disease (1), congestive heart failure (2) and cirrhosis (3). Resident #1's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/27/2020, coded Resident #1 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident #1 was not documented as requiring oxygen while a resident at the facility. The comprehensive care plan for Resident #1 dated "12/15/2020" documented in part, "Hepatic condition related to Cirrhosis. Date Initiated: 11/23/2020." Under "Interventions", it documented in part, "Report difficulty breathing to physician. Date Initiated: 11/23/2020 ..."	F 580		1/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/18/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 The care plan further documented, "Renal insufficiencies related to: chronic renal failure. Date Initiated: 11/23/2020." Under "Interventions", it documented in part, "Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis as needed. Date Initiated: 11/23/2020 ..." Review of the facility progress notes for Resident #2 revealed the following in part: "12/4/2020 12:49 (12:49 p.m.) Skilled nursing ... Resident is alert and oriented. Denied pain or discomfort. Appetite fair, requires set up for meals. No behaviors noted. Resident voiced being upset this morning related to having an incontinent episode of stool ...Resident stated, she knows it's from the Lactulose and understand the reason she has to take it ..." "12/6/2020 14:36 (2:36 p.m.) Skilled nursing ...Resident is alert and oriented. Denied pain or discomfort ...No s/s (signs and symptoms) of shortness of breath or coughing." "12/7/2020 16:31 (4:31 p.m.) Skilled nursing ...Resident is alert and verbal, skin warm and dry to touch, up in wheelchair. Able to make needs known ..." "12/8/2020 02:59 (2:59 a.m.) Skilled nursing ...Ambulating in hallways using walker, re-directed to time and place, refused to go back to bed ..." "12/8/2020 06:52 (6:52 a.m.) Resident out to dialysis around 6:00, resident c/o (complains of)	F 580		1/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/18/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4	F 580		1/15/2021

sob (shortness of breath), O2 (oxygen) sat (saturation) 94-97% on rom [sic] air, O2 sat 98% with O2 at 2 LNC (liters nasal cannula), VS 124/66 (blood pressure), 78 (pulse), 18 (respirations), denies pain. O2 applied per transport request in case she needed later. Dialysis nurse call [sic], stated sent resident to [Name of Hospital], she call [sic] placed to family, but did not get an answer, supervisor notifie [sic]."

"12/8/2020 06:56 (6:56 a.m.) Call placed to MD (medical doctor) unable to contact no answer."

"12/8/2020 10:10 (10:10 a.m.) Writer attempted to speak with RP (responsible party), she was crying and yelling, then stated "what are you talking about? My mother is in ICU (intensive care unit) right now, I have another call I have to go."

The facility "Hemodialysis Communication Form" dated 12/8/20 for Resident #1 documented in part, " ...Significant change/decline since last dialysis treatment- No. Fall risk: Yes (explain) Weakness, Dizziness, c/o (complaints of) SOB (shortness of breath), O2 (oxygen) Sat (saturation) 98% on room air ...Patient Status: Confused ...Changes in medications regimen since last dialysis treatment: O2 at 2 LNC (liters nasal cannula) resident awake all night walking in hallway ..."

On 12/16/20 at approximately 7:15 a.m., a telephone interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that Resident #1 was a dialysis patient and had a scheduled appointment to be picked up between 5:00 and 5:30 a.m. on their dialysis days. LPN #3 stated that Resident #1 was restless the night

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/18/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 before they were sent to dialysis on 12/8/20. When asked about the progress note dated 12/8/20 which documented Resident #1 complaining of shortness of breath, LPN #3 stated that Resident #1 was up moving around during the night and restless but not complaining of shortness of breath or pain. LPN #3 stated that Resident #1 told them that they would feel better after dialysis. LPN #3 stated that Resident #1 was anxious but requested to go to dialysis the morning of 12/8/20. LPN #3 stated that they checked Resident #1's vital signs and they were normal, and oxygen saturations, which were 94-96% on room air. LPN #3 stated that the transport driver requested the oxygen for Resident #1 to have in case they became short of breath during transport. LPN #3 stated that they placed Resident #1 on oxygen at 2 liters per minute by nasal cannula as a precaution at the request of the resident and the van driver. LPN #3 stated that Resident #1 left the facility in a wheelchair with a wheelchair van service on 2 liters of portable oxygen by nasal cannula. LPN #3 stated that Resident #1 was not short of breath or in any distress when they left the facility to go to dialysis. LPN #3 stated that they attempted to contact the physician after Resident #1 had left the facility to get an order for the oxygen but they did not answer the phone. LPN #3 stated that about one and a half hours after Resident #1 left the facility the dialysis nurse called them and told them that Resident #1 had been sent to the emergency room. On 12/16/20 at approximately 3:20 p.m., a telephone interview was conducted with OSM (other staff member) #2, transportation service van driver. OSM #2 stated that they picked up Resident #1 on 12/8/20 for their scheduled	F 580		1/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/18/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6 dialysis appointment. OSM #2 stated that normally they have conversations with Resident #1 and they could tell that something was not right. OSM #2 stated that Resident #1 was moaning and groaning and only answering by saying "uh-huh" or "yeah." OSM #2 stated that he alerted the nurse and asked for vital signs to be taken. OSM #2 stated that the nurse assessed Resident #1 and recorded the vital signs on a paper and then put Resident #1 on oxygen at 2 liters for transport to dialysis. On 12/18/20 at approximately 8:45 a.m., a telephone interview was conducted with CNA (certified nursing assistant) #2. CNA #2 stated that Resident #1 normally stayed in their room at night but was out walking in the hallway with their walker the night before dialysis on 12/8/20. CNA #2 stated that Resident #1 was not in any distress or short of breath when they assisted them to get dressed for dialysis on 12/8/20. CNA #2 stated that Resident #1 complained of being sleepy. CNA #2 stated that the nurse asked them to recheck Resident #1's vital signs after the van driver had requested the nurse to assess the resident. CNA #2 stated that the vital signs were within normal limits and they reported the vital signs to the nurse and the van driver who were there with them when they checked the vital signs. CNA #2 stated that they left to care for another resident after that and the nurse left to obtain oxygen to place on Resident #1. On 12/18/20 at approximately 9:00 a.m., a telephone interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that in an emergency situation staff were allowed to initiate oxygen on a resident at 2 ltr/min(liters per minute) to treat the	F 580		1/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/18/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7 situation right away and were to notify the physician as soon as possible to update them on the status of the resident and obtain the order for the oxygen. ASM #2 stated that LPN #3 had notified them that they had sent Resident #1 out to dialysis with oxygen on 12/8/20 as a precaution because they were anxious and the van driver and Resident #1 wanted them to have it during transport in case they needed it. ASM #2 stated that LPN #3 reported to them that Resident #1 and the van driver wanted them to go to dialysis with the oxygen. ASM #2 stated that when they spoke with LPN #3 they stated that they documented Resident #1 being short of breath by mistake and that Resident #1 was only complaining of anxiety when they left for dialysis on 12/8/2020. ASM #2 stated that LPN #3 had attempted to contact Resident #1's physician after Resident #1 left the facility to get the order for the oxygen but they had not answered. ASM #2 stated that staff used the chain of command if they were unable to reach the attending physician or nurse practitioner for a resident, they would contact the medical director after one hour unless it was an emergency. ASM #2 stated that staff would be expected to have contacted the physician to obtain the order for the oxygen. ASM #2 stated that Resident #1 was confused normally and their oxygen saturations were within normal limits on room air when they were transported to dialysis on 12/8/2020. On 12/17/20 at approximately 8:50 a.m., ASM #1, the administrator stated via email that the facility uses Lippincott for their nursing standard of practice. On 12/18/20 at approximately 9:10 a.m., a request was made to ASM #2 for the facility policy	F 580		1/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/18/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8 on oxygen administration and physician chain of command. On 12/18/20 at approximately 9:50 a.m., ASM #1 stated that the facility did not have a policy in regards to physician notification chain of command. ASM #1 stated, "If the physician is not reachable the DON (director of nursing)/supervisor would be notified as well." The facility policy "Oxygen Administration" documented in part, " ...During a respiratory emergency it is appropriate for nursing to administer oxygen immediately and obtain physician's order after patient is stabilized or transferred..." The facility policy failed to evidence guidance for staff administration of oxygen in non-emergenct situations without consulting the physician. The facility policy "Change in Condition" documented in part, "Purpose: To provide guidance in the identification of clinical changes that may constitute a change in condition and require intervention and notifications ...According to the American Medical Directors Association (AMDA) Clinical Practice Guidelines- Acute Changes in Condition In the Long-Term Care Setting.- Immediate notification is recommended for any symptom, sign or apparent discomfort that is acute or sudden in onset and a marked change in relation to usual symptoms and signs, or is unrelieved by measures already prescribed ..." According to Lippincott Nursing Procedures, Seventh Edition, Lippincott Williams & Wilkins, 2015, page 573-577, "Oxygen Administration ...Implementation: Verify the practitioner's order for the oxygen therapy because oxygen is	F 580		1/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/18/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 9 considered a medication or therapy and should be prescribed ...Documentation: Record the date and time of oxygen administration; the type of delivery device; the oxygen flow rate; the patient's vital signs, skin color, respiratory effort, and lung sounds; his response before and after initiation of therapy; complications and the nursing actions taken; and any patient or family teaching." On 12/18/20 at 10:15 a.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. Complaint deficiency Reference: 1. End-stage kidney disease The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm. 2. Congestive heart failure A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 3. Cirrhosis A scarring of the liver and poor liver function. It is the last stage of chronic liver disease. Cirrhosis	F 580		1/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/18/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 10 is the end result of chronic liver damage caused by chronic (long-term) liver disease. Common causes of chronic liver disease in the United States are: Hepatitis B or hepatitis C infection or alcohol abuse. This information was obtained from the website: https://medlineplus.gov/ency/article/000255.htm.	F 580		1/15/2021