PRINTED: 01/07/2021 FORM APPROVED OI/B NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-RICHMOND		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3 DATE SURVEY COMPLETED
		495045	B. WING		
			STREET ADDRESS, CITY, STATE, ZIP COD 2125 HILLIARD ROAD RICHMOND, VA 23228	01/04/2021 DE	
(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)	SHOULD BE COMPLETION
E 000	Preparedness COV conducted 12/30/20 facility was in substa Part 483.73, Require Facilities.	bbreviated Emergency ID-19 Focused Survey was 20 through 1/4/2021. The antial compliance with 42 CFR ement for Long-Term Care	E 00	The Statements made on this plan not an admission to and do not consider within the alleged deficiencies cite in compliance with all federal and the center has taken or will take the in the following plan of correction center's allegation of compliance cited have been or will be corrected dates indicated.	onsitute an agreement and herein. To remain state regulations, ne actions set orth consitutes the
	Focused Survey was through 1/4/2021. Co	obreviated COVID-19 s conducted 12/30/3030 orrections are required for CFR Part 483 Federal Long	F 000		
F 883 I	149. Of the 149 cure had tested positive fo survey sample consist reviews, (Residents closed record review	ococcal Immunizations	F 883	1. Cited Residents: #1 resident/RP were provided educe #2 is no longer a resident in the face #3 RP was provided education on in pneumococcal vaccinations #5 Resident was provided educatio influenza vaccine	ility. nfluenza ɛnd
g (i) e re p (i) in ai co in	officies and procedure) Before offering the ach resident or the resident or the resident is officially ach resident is officially ach resident is officially, unless the incontraindicated or the amunized during this	za. The facility must develop es to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; fered an influenza 1 through March 31 nmunization is medically resident has already been		2. Like Residents: Residents admitting into the center that are long term have the potentia An audit was completed on admissis two weeks to ensure that consents a were obtained, documented, and up Newly admitted resident will be offer vaccination if they have not already and will be offerred the influenza vato the influenza season availability, educationwill be documented in the with copies to be placed in charts. #3 Education will be provided to licer documenting the consent and education pneumococcal and influenza vaccinations to the place of the previous contents of the previous conten	I to be affected. ons in the last and educations dated as necessary. red the pneum poccal had the vaccir's coine according Consents and clinical record

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

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		& MEDICAID SERVICES			ON 1B NO. 0938-039
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIF A. BUILDING	(X) DATE SURVEY COMPLETED	
		495045	B. WING		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/04/2021
MANORCARE HEALTH SERVICES-RICHMOND				2125 HILLIARD ROAD RICHMOND, VA 23228	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD 3E COMPLETION
	(iv)The resident's redocumentation that following: (A) That the reside was provided educt and potential side eximmunization; and (B) That the resider immunization or dictimmunization due to refusal. §483.80(d)(2) Pneumust develop policion that— (i) Before offering the immunization, each representative receiptenefits and potential immunization; (ii) Each resident is immunization, unless medically contraindical ready been immunication that in the contraint of the communication that in the contraint of the communication that in the contraint of the communication; (ii) The resident or the communication that in the contraint of the communication that in the contraint of the communication; and B) That the resident one unococcal immunication that the resident one unococcal immunication that the resident one unococcal immunication that in the resident one unococcal immunication that the resident one unococcal immunication that in the resident one unococcal immunication that in the resident one unococcal immunication; and the resident one unococcal immunication that in the resident one unococcal immunication that it is the resident of the resident one unococcal immunication that it is the resident of the resi	refuse immunization; and medical record includes to indicates, at a minimum, the ent or resident's representative ation regarding the benefits effects of influenza to the either received the influenzation medical contraindications or emococcal disease. The facility estand procedures to ensure the pneumococcal resident or the resident's vest education regarding the earliest effects of the ensure the immunization is cated or the resident has existed; the resident's representative to refuse immunization; and edical record includes endicates, at a minimum, the entered or regarding the benefits existed or the received the enization or did not receive immunization or did not receive immunization due to medical	F 88.	#4 The Director of Nursing, or design monitor consents and education for b and influenza vaccinations weekly x4 to ensure that consents are obtained documented with copies in the clinical Results of the QAPI audits will be revifacility's QAPI Committee. Recommer discussed and implemented as needed. #5 The Facility's alleged date of comp February 16, 2021	oth pheumococcal and monthly x2 and a ducation is I record. ewed by the idations will be d.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495045	B. WING		01/04/2021	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-RICHMOND			212	REET ADDRESS, CITY, STATE, ZIP CODE 25 HILLIARD ROAD CHMOND, VA 23228	The state of the s	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
	by: Based on staff interest and clinical record facility staff failed to provided to the resist prior to receiving or or pneumococcal versidents in the sur #2, #3, and #5. The findings included 1. Resident #1 was 8/8/2020 with diagnost limited to: anxiet gastroesophageal recontents of the stone usually caused by not muscle between the include burning pair known as heartburn (minimum data set) assessment, with an (ARD) of 12/4/2020, scoring an "11" on the mental status) score moderately impaired decisions. Review of the clinical received an 11/6/2020. The clinical record failed of education provide	erview, facility document review review, it was determined the evidence education was dent and/or responsible party declining an influenza vaccine accine for four of seven vey sample, Residents # 1.	F 883			

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CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROV	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495045 NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			1B NO. 0938-039 DATE SURVEY COMPLETED
		B. WING				
MANORCARE HEALTH SERVICES-RICHMOND				STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD		01/04/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	30	(X5) OCMPLETION DATE
F 883	A request was made to ASM (administrator, via exprovided for the infloon 11/6/2020. An interview was considered by the constant of the infloor the infloor 12/2020.	tive staff member) #1, the mail, for the education uenza vaccine administered and the director of nursing. Sumentation of the education dent and/or the responsible	F 88			
is A	party, ASM #2 state done as she has no education only of the documented in part, available to share w (centers for disease Immunization Information: Season to Infection Control Medical Services have the CDC website and Clinical Services have Resources>Infection Information: Season to Infection Control Medical Services have the patient or the particular of the patient or	d that she can't tell if it was documentation of the e consent obtained. Influenza Immunization Plan" "Educational materials are th patients. The CDC control) Inactivated Influenza ation Sheet is available on d can also be found on the exclinical Prevention> Influenza (current year)> Addendums flanual> Influenza Inactivated egal representative is nity to refuse immunization. Atient's legal representative is education and consultation is of influenza immunization mented." Were made aware of the 31/2020 at 2:45 p.m.				
R	eferences:	was provided prior to exit.				
	, Danion's Dictionary	of Medical Terms for the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495045	B. WING			01/04/2021
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-RICHMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 3E	(X5) COMPLETION DATE
F 883	Continued From page 4 Chapman, page 243. 2. Resident #2 was admitted to the facility on 3/18/2020 and discharged to the hospital on 12/30/2020, with diagnoses that included but were not limited to: COVID -19 (A novel coronavirus is a new coronavirus that has not been previously identified. The virus causing coronavirus disease 2019 [COVID-19], is not the same as the coronaviruses that commonly circulate among humans and cause mild illness, like the common cold (1), diabetes, high blood pressure and gastroesophageal reflux disease. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 12/11/2020, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating they were capable of making daily cognitive decisions.		F 883			
	Immunization tab in (EMR) it was docum the pneumococcal of the pne	the electronic medical record mented the resident received raccine on 3/21/2020. e on 12/31/2020 at 9:18 a.m., inistrator, via email, for the for the pneumococcal vaccine 0/2020. The consent for and t #2's influenza vaccine was anducted on 12/31/2020 at #2, the director of nursing. umentation of the education t #2 and/or the responsible				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	T	OI/B NO. 0938-039	
		IDENTIFICATION NUMBER:	A. BUILDIN	(X3 DATE SURVEY COMPLETED	
		495045	B. WING		
NAME OF	PROVIDER OR SUPPLIER			CTDEST AS A	01/04/2021
	CARE HEALTH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228	
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD SE SOUR EST
	F 883 Continued From page 5 party for the administration of the pneumococcal vaccine, ASM #2 stated the resident was her own responsible party. I do not have the documentation of the education provided. When asked about the influenza vaccine, ASM #2 stated the resident had refused it at first and she had no further documentation of it being offered. ASM #1 and ASM #2 were made aware of the above concern on 12/31/2020 at 2:45 p.m. No further information was provided prior to exit. References (1) This information was obtained from the following website: https://search.cdc.gov/search/index.html?query=COVID+-+19+definition&sitelimit=&utf8=%E2%9C%93&affiliate=cdc-main#content.		F 88	33	
the control of the co	e/6/2019 with diagnosmot limited to: COVID depression, and sickle blood disease, occurryhich abnormal hemosells to become sickle confunctional, leading ecent MDS assessment, with an Americal expension of the resident as scoring adicating the resident aily cognitive decision.	to anemia) (1). The most ent, a quarterly ARD of 10/9/2020, coded g a "13" on the BIMS score, was capable of making as.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X) DATE SURVEY COMPLETED	
		495045	B. WING		01	/04/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-RICHMOND		STREET ADDRESS, CITY, STATE, ZIP COD 2125 HILLIARD ROAD RICHMOND, VA 23228	E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY 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	(X5) COMPLETION DATE	
F 883	to ASM (administratia administrator, via emprovided for the influvaccines that that will Resident #3 in the control of the influvaccines that that will Resident #3 in the control of the influence and vaccine of the education provided both the influence and vaccinations, ASM #3 on the dementia univould have been condocumentation of an responsible party. ASM #1 and ASM #3 above concern on 13 No further information. References: (1) Barron's Dictional Non-Medical Reader Chapman, page 530 4. Resident #5 was a 7/16/2020 with diagrant limited to: high big gastroesophageal repostructive pulmonal chronic, nonreversibal a combination of embronchitis) (1). The massessment, a quarter ARD of 12/17/2020,	e on 12/31/2020 at 9:18 a.m., ive staff member) #1, the nail, for the education penza and pneumococcal as documented as refused for linical record. Inducted on 12/31/2020 at #2, the director of nursing. documentation of the prior to Resident #3 declining and pneumococcal #2 stated, the resident resides to the responsible party intacted. I do not have by education provided to the provided to the provided prior to exit. In was provided prior to exit. In yof Medical Terms for the provided to the provided to the provided to the provided prior to exit. In yof Medical Terms for the provided to the provided but were provided but were provided but were provided pressure, and chronic provides that included but were provided but were provided to the provided pressure, and chronic provided to the susually physema and chronic provided but were provided to the facility on the provided pressure, and chronic provided to the facility on the provided pressure, and chronic provided to the facility on the provided pressure, and chronic provided to the facility on the provided pressure, and chronic provided to the facility on the provided pressure, and chronic provided to the facility on the provided pressure, and chronic provided pressure, and chronic provided pressure provided pressure, and chronic provided pressure provided provided pressure provided pr	F 883				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	(X.) DATE SURVEY COMPLETED	139	
		495045	B. WING		01/04/2021	
	PROVIDER OR SUPPLIER CARE HEALTH SERVICE		21:	REET ADDRESS, CITY, STATE. ZIP CODE 25 HILLIARD ROAD CHMOND, VA 23228	1 01/04/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY 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 AP DEFICIENCY)	HOULD BE COMPLET	
	resident was capable decisions. Review of the clinic documentation the administered to Research administrator, via enconsent provided to pneumococcal vacca administered on 9/2 An interview was consent provided to pneumococcal vacca administered on 9/2 An interview was consent provided the pneumococcal vacca administered on 9/2 An interview was consent provided the pneumococcal vacca administered on 9/2 An interview was consent provided the pneumococcal vaccation provided the pneumococcal vaccation provided. ASM #1 and ASM #2 own responsible parany documentation of provided. ASM #1 and ASM #2 above concern on 12 No further information Reverences: (1) Barron's Dictional Control of the control of	cal record revealed pneumococcal vaccine was sident #5 on 9/20/20. e on 12/31/2020 at 9:18 a.m., tive staff member) #1, the mail, for the education and a Resident #5 for the sine that was documented as 20/2020. Inducted on 12/31/2020 at #2, the director of nursing, documentation of the prior to the administration of accine to Resident #5 on stated the resident was their than the could not locate of the education that was 2 were made aware of the 2/31/2020 at 2:45 p.m. In was provided prior to exit. Party of Medical Terms for the 2,5th edition, Rothenberg and	F 883			