

May 25, 2016

Ms. Wietske G. Weigel-Delano

LTC Supervisor

OLC, Division of Long Term Care Services

9960 Mayland Drive

Suite 401

Richmond, VA 23233

Ms. Delano,

Please find enclosed our Plan of Correction for Survey ending April 21, 2016 with corrections made to F250, F314, and F282. Our alleged date of compliance is May 26, 2016

Should you have any questions, please feel free to contact me.

Thank You,

Kelly Carter

Administrator

Enclosure:

2567



COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP State Health Commissioner

Office of Licensure and Certification

TYY 7-1-1 OR 1-800-828-1120

9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1485 FAX: (804) 527-4502

May 5, 2016

Mis. Kelly Carter, Administrator The Laurels Of University Park

2420 Pemberton Rd Richmond, VA 23233

RE:

The Laurels Of University Park

Provider Number 495109

Dear Ms. Carter:

An unannounced standard survey, ending April 21, 2016, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Three complaints were investigated during the survey. Two complaints were substantiated, with deficiencies. One complaint was unsubstantiated, with no deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of F), as evidenced by the attached CMS-2567L, whereby corrections are required.

COPN

LONG TERM CARE

(804) 367-2100

Ms. Kelly Carter, Administrator May 5, 2016 Page 2

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Wietske G Weigel-Delano, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained and

5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at "http://www.vdh.state.va.us/OLC/longtermcare/".

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

Ms. Kelly Carter, Administrator May 5, 2016 Page 3

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

Pursuant to §488,408(c)

Directed Plan of Correction (PoC) (§488.424).

State monitoring (§488.422).

Directed In-Service Training (§488.425).

Pursuant to §488.408(d)

Denial of payment for new admissions - (§488.417).

Denial of payment for all individuals - (§488.418).

- Civil Money Penalty, \$50 \$3,000 per day (§488.430, §488.438), effective on the survey ending date,
- Civil money penalties of \$1,000 \$10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Ms. Kelly Carter, Administrator May 5, 2016 Page 4

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please this complete "http://www.vdh.state.va.us/OLC/longtermcare/". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Wietske G Weigel-Delano, LTC Supervisor

Division of Long Term Care

Enclosure

Joani Latimer, State Ombudsman CC:

Jaime Desper, D M A S (Sent Electronically)

PARTMENT OF	HEALTH AND HUMAN SERVICES			"A" FORM DATE SURVEY
		PROVIDER#	MULTIPLE CONSTRUCTION	COMPLETE:
ATEMENT OF ISOL	ATED DEFICIENCIES WHICH CAUSE X A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	4/21/2016
HARM WITH ONL R SNFs AND NFs	X A POTENTIAL TOTAL	495109	B. WING	4/21/2010
K ants and in			CITY, STATE, ZIP CODE	
AME OF PROVIDE	OR SUPPLIER	2420 PEMBER	TON RD	
	OF UNIVERSITY PARK	RICHMOND, V	/A	
HE LAUKELS	OF CIVIL ENGINE			
D		VOLET		
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i i			! ^~ 3081781 18111636 W 4	access all
7	The resident or his or her legal repre	esentative has the rig	ht upon an oral of written request, clinical records within 24 hours (exc ecords for inspection, to purchase at a	luding
1 1	1 d constattatty statualy pre-	10000	ecords for inspection, to purchase up a rds or any portions of them upon requ	
	working days advance notice to the	facility.		
		<u> </u>		
	This REQUIREMENT is not met	as evidenced by:	4. 4 of n	compliant
	This REQUIREMENT is not increased.	interview, facility do	cument review, and in the course of a iled to provide copies of the clinical re	ecord to the
	Based on stall interview, resolution it was determined that	it the facility staff fai	cument review, and in the course of a iled to provide copies of the clinical re the survey sample, Resident # 13.	
			1 2/21/16 RESIDENLE	13 documented
	A request was made by the Resider	wed a copy of his rec	nedical record on 3721/10. Resident and ord (approximately five days after the	request
	that as of 3/28/16 he had not receive excluding holidays and weekends)	,		
ļ	excluding holidays and weekens			
	The findings include:			
		facility on 7/20/15	with diagnoses including, but not limi and high blood pressure.	ted to: neurogenic
	bladder, hyperiipidenna, parupies	, ,	sessment), a quarterly assessment with 1 the resident's BIMS (brief interview	ARD (assessment
	On the most recent complete MD	S (minimum data ass	sessment), a quarterly assessment), a quarterly assessment as the resident's RIMS (brief interview	for metal status) as
	reference date) 12/31/15, Residen	at # 13 was coded of	sessment), a quarterly assessment with the resident's BIMS (brief interview intact.	
Ì	reference date) 12/31/15, Resident 15 out of 15, indicating Resident	开15.8 Cogmmon was		ont # 13 the request
	/ / / / / / / / / / / / / / / / / / /	at 4:10 p.m. and agai	n on 4/20/16 at 3:00 p.m. with Reside	for an apartment
	During an interview on 4 12/10.	ed. Resident # 13 sta	n on 4/20/16 at 3:00 p.m. with Reside tied that he was trying to get approved ese interviews corroborated the infor	nation in the hand
	written complaint. Documentation	on in the hand written	n complaint form, dated 3/28/16, level ments) indicating to me that an apartra acilities administrator about the apartra tricen (not	nent was available
	"On 3-21-2016 I received a can	LinForm (sic) the Fa	acilities administrator about the apart	me of advisor). A
	and I could move in on 3/2/10.	information to give	acilities administrator about the apart to my independent living advisor (nat 1:00 a.m. For myself, my ombudsman	(name of advisor),
\	would need my medical resorted	(sic) 4-6-2016 at 11	to my independent living advisor (name ::00 a.m. For myself, my ombudsman. ents."	
				from the apartments
	During an interview on 4/20/16	went to the administ	esident # 13 he stated, "I got the call t trator and requested my records. An a eady. I got the records about a week a	appointment was for Lrequested
	on 3/21/16 and that same day I	n have everything re	trator and requested my records. And a week a cady. I got the records about a week a	IRCI I Icducano
	setup for 4/6/16 and 1 warned			
	them."			

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 plans of correction are disclosable 14 days following the date these documents are made available to the facility.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

EPARTME	NT OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICAID SERVICES		MULTIPLE CONSTRUCTION	DATE SURVEY
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	Continued From Page 1		this concern W	as discussed.
F 153	Continued From Page 1 During an interview on 4/20/16 at 1	0:40 a.m. with ASM i	# 1, the administrator, this concern w	documentation
			this time a request was made for any	
	1 Decident # 13'S ICUUCSI	[Of Hicorografia		
	Concerning		nan was made and a message was lef	t. No return call
	On 4/20/16 at 4:33 p.m. an attempt	to reach the ombudsi	man was made and a man a	
	the survey diffing the survey.			
		GODILE at approxim	ately 6:00 p.m., ASM (administrativ ASM # 3, the regional Quality Assura	e staff member) — — — —
	During the end of day interview on	4/20/10 at approxim	ASM # 3, the regional Quality Assurations concern. At this time a request	ince Manager,
	μι the administrator. ASM #2, μις	UITCOIOT OF TENA	. At this time a request i	was made for any
	and ASM # 4, the Regional Manag	ony of Resident # 13	this concern. At this time a requestion agreement and the facility	ty policy loi
	additional information and also a c	Ору 01 21		
	medical records requests.		are a surrenid find no	documentation as
	4 : 140 an 4/21/16 at 7:40 a.	m. with ASM # 1 rev	realed the following: "I could find no s of his recordhe did get them, just the copies of the records.	not sure when."
	An interview of 4227 to the sked to the sked to	for or received copies	s of his record ne and get ment, just	
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	During an interview on 4/21/16 at	9:00 a.m. with USIM	OSM #2 stated that she would direct request goes to medical records.	those requesting
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

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i		ļ	severity of any of	the cited	
The facility must	t inform the resident both orally		deficiencies, or c		
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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.

program para ;

Event ID: H82911

Facility ID: VA0249

If continuation sheet Page 1 of 122

RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		MULTIPLE CONSTRUCTION		(X3) DA	TE SURVEY MPLETED
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A posting of na numbers of all groups such as agency, the State ombudsman padvocacy network; and a state ombudsman astate of the state	mes, addresses, and telephone pertinent State client advocacy the State survey and certification at licensure office, the State program, the protection and work, and the Medicaid fraud contement that the resident may file the State survey and certification	on trol a				
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PRINTED: 05/05/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION C 04/21/2016 B. WING 495109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX DEFICIENCY) TAG F 156 F 156 Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced bv: Based on staff interview and closed clinical record review, the facility staff failed to provide written notification of discontinuation of services (Generic Notice) and the right to appeal this decision prior to discharge home from the facility for one of three closed records reviewed for this F Tag 156 notice, Resident # 24. Resident #24 was discharged The facility failed to provide notice of from the facility on 2/11/16. discontinuation of services via the Notice of Provider Non-coverage also known as the "Generic Notice" form to Resident # 24 prior to her discharge to home on 2/11/16. Resident # 24 All current residents have the

at the time of discharge.

The findings include:

had 64 days of Skilled Nursing coverage available

potential to be affected.

A BUBLING A PEROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK THE LAURELS OF UNIVERSITY PARK STREET ADDRESS, CITY, ENTRE ZIP CODE 2420 PEMBERTON RD RICHMOND, VA. 22233 PROMISERS AND OF CORRECTION RICHMOND, VA. 22233 PROMISERS AND OF CORRECTION RICHMOND, VA. 22233 PROMISERS AND OF CORRECTION PARAMOND RICHMOND, VA. 22233 PROMISERS AND OF CORRECTION RICHMOND, VA. 22233 PROMISERS AND OF CORRECTION PROMISES PROMISES PR		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	PLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF				
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## PRECIDENT OF UNIVERSITY PARK CACH DUST CENTY MASS TRATEMENT OF DEPCISACIES DEPCISACIES PRODUCES PLAN OF CORRECTION CACHE PROPERTY	NAME OF F	PROVIDER OR SUPPLIER			l			
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# 1, ASM # 1 reported that there was no Generic Notice available for Resident # 24. During the end of day interview on 4/20/16 at approximately 6:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM # 3, the regional Quality Assurance Manager, and ASM # 4, the Regional Manager, were informed of this concern. During an interview on 4/21/16 at approximately 8:10 a.m. with ASM # 1, a request for the facility policy was made. Puring an interview on 4/21/16 at 8:35 a.m. with results to the NHA. Any variances will be corrected and continuing education will be provided. The Regional Business Office manager will review discharges randomly thereafter to assure the process remains in place and will report and variances to		= 3.00 n.m. with AS	M (administrative staff member)		wooldy for A week	re and reno	rt !
Notice available for Resident # 24. During the end of day interview on 4/20/16 at approximately 6:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM # 3, the regional Quality Assurance Manager, and ASM # 4, the Regional Manager, were informed of this concern. During an interview on 4/21/16 at approximately 8:10 a.m. with ASM # 1, a request for the facility policy was made. During an interview on 4/21/16 at 8:35 a.m. with the residue of the facility process remains in place and will report and variances to the NHA.		# 1. ASM # 1 rep	orted that there was no Generic					11
During the end of day interview on 4/20/16 at and continuing education will approximately 6:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM # 3, the regional Quality Assurance Manager, and ASM # 4, the Regional Manager, were informed of this concern. During an interview on 4/21/16 at approximately 8:10 a.m. with ASM # 1, a request for the facility policy was made. During an interview on 4/21/16 at 8:35 a.m. with the NHA.		Notice available f	for Resident # 24.					
approximately 6:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM # 3, the regional Quality Assurance Manager, and ASM # 4, the Regional Manager, were informed of this concern. During an interview on 4/21/16 at approximately 8:10 a.m. with ASM # 1, a request for the facility policy was made. During an interview on 4/21/16 at 8:35 a.m. with During an interview on 4/21/16 at 8:35 a.m. with be provided. The Regional Business Office manager will review discharges randomly thereafter to assure the process remains in place and will report and variances to	l							
administrator, ASM #2, the director of nursing, ASM # 3, the regional Quality Assurance Manager, and ASM # 4, the Regional Manager, were informed of this concern. During an interview on 4/21/16 at approximately 8:10 a.m. with ASM # 1, a request for the facility policy was made. During an interview on 4/21/16 at 8:35 a.m. with During an interview on 4/21/16 at 8:35 a.m. with The Regional Business Office manager will review discharges randomly thereafter to assure the process remains in place and will report and variances to the NHA.		During the end of	f day interview on 4/20/10 at				ucation wi	<u> </u>
ASM # 3, the regional Quality Assurance Manager, and ASM # 4, the Regional Manager, were informed of this concern. During an interview on 4/21/16 at approximately 8:10 a.m. with ASM # 1, a request for the facility policy was made. During an interview on 4/21/16 at 8:35 a.m. with During an interview on 4/21/16 at 8:35 a.m. with The Regional Business Office manager will review discharges randomly thereafter to assure the process remains in place and will report and variances to the NHA.		approximately 6:	UU p.m., Advi #1, uie	-		be provided.		
Manager, and ASM # 4, the Regional Manager, were informed of this concern. During an interview on 4/21/16 at approximately 8:10 a.m. with ASM # 1, a request for the facility policy was made. During an interview on 4/21/16 at 8:35 a.m. with During an interview on 4/21/16 at 8:35 a.m. with		administrator, Ac	ional Ouality Assurance	:		•		
were informed of this concern. During an interview on 4/21/16 at approximately 8:10 a.m. with ASM # 1, a request for the facility policy was made. During an interview on 4/21/16 at 8:35 a.m. with the NHA.		Manager and AS	SM # 4, the Regional Manager,					ee
During an interview on 4/21/16 at approximately 8:10 a.m. with ASM # 1, a request for the facility policy was made. During an interview on 4/21/16 at 8:35 a.m. with discharges randomly thereafter to assure the process remains in place and will report and variances to the NHA.		were informed of	f this concern.	:		manager will revi	ew	ŧ
8:10 a.m. with ASM # 1, a request for the facility process remains in place and policy was made. During an interview on 4/21/16 at 8:35 a.m. with process remains in place and will report and variances to the NHA.								
8:10 a.m. with ASM # 1, a request for the facility process remains in place and policy was made. During an interview on 4/21/16 at 8:35 a.m. with process remains in place and will report and variances to the NHA.		During an intervi	ew on 4/21/16 at approximately	1		thereafter to assur	e the	
During an interview on 4/21/16 at 8:35 a.m. with will report and variances to the NHA.		8:10 a.m. with A	SM # 1, a request for the facility					
During an interview on 4/21/16 at 8:35 a.m. with the NHA.		policy was made	a.			will report and va	riances to	
OSM (other staff member) # 2, the social worker,		D	iow on 4/21/16 at 8:35 a.m. with					. —
		During an intervi	f member) # 2, the social worke	r,		the initial		

CENTERS FOR MEDICARE	& MEDICAID SERVICES	(X3) WHILE	TIPLE CO	NSTRUCTION	(X3) DAT	E SURVEY MPLETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ŀ	
AND PLAN OF CONNECTION						C /21/2016
	495109	B, WING		ET ADDRESS, CITY, STATE, ZIP CODE	1 04)	21/2010
NAME OF PROVIDER OR SUPPLIER						
	TV BARK			PEMBERTON RD IMOND, VA 23233		
THE LAURELS OF UNIVERSI			KICH	DROVIDER'S PLAN OF CORRECTI	ON	(X5)
(A4) IV (SUI DECIDIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
		:				
F 156 Continued From p	age 4		156	Continued compliance wi	il be	
the process to issi	ne a Generic Notice (referred to			monitored through the		
by the social WOLK	er as a "cut lettel". Usivi # 4	:	:	facility's quality assurance	e	
Micusius de de de l'eurolly	dives the form to resident	! 		program. Additional		
() +	ata tamiiy in sinu. Hell liib iyiri			education and monitoring	will	
in which to the bus	siness office. She finds out who the ITM (interdisciplinary team			be initiated for any identi-	fied	
is going home at t	n gets the form signed. She	•		concerns.		
not the cocia	I MORKER ASSIGNED ID DIE					
resident so she de	oesn't know what happened.		:	Completion Date:		
\			:	May 26, 2016		
During an intervie	ew on 4/21/16 at 9:30 a.m. with	:		1,14, 20, 211		
ASM # 1, the adn	ninistrator, ASM #1 stated that policy but does follow the		-			
the facility has no	presented a copy of the					
instructions on is	suing a notice.	i				
. 1			•			
These instruction	ns documented: "Form		•			1
Instructions for the	ne Notice of Medicare		:			
Non-Coverage (1	NOMNC) CMS-10123." r the NOMNC: A Medicare		:			
lvidor or healt	h nlan (Medicare Advantage					
where and cost n	lane collectively reterred to as					:
luland") must de	diver a completed copy of the	:				
Nation of Modics	are Non-Coverage (NOMINO) to					
beneficiaries/en	rollees receiving covered skilled ealth (including psychiatric home	3				!
nursing nome in	hensive outpatient rehabilitation	:				
seattle and has	nice services.		· · · · · ·			
UTL - NOMANIC m	auet he delivered at least two					
landor dove h	Sefore Medicare covered service	20	!			
end or the seco	ind to last day of service if care i					1
not being provid	ieu daily		!	<u>.</u> :		1
:		1				
No further infor	mation was provided prior to ex	it.	E 050			!
= 250 483 15(d)(1) PE	ROVISION OF MEDICALLI		F 250	1 1 2		
SS=D RELATED SOC	CIAL SERVICE			· •		
					44	1 1 Dans E of 19

CENTERS FOR MEI	DICARE & MEDICALD	SERVICES	VOLMULTIP	E CONSTRUCTION		(X3) DATE SUF	RVEY ED
CTATEMENT OF DEFICIENC	IES (X1) PROVIDERS	SUPPLIER/CLIA TON NUMBER:	A, BUILDING			C	
AND PLAN OF CORRECTION	122///					04/21/2	2016
	49	15109	B. WING	22222	CITY, STATE, ZIP CODE	Q-11 Ad 11 Z	
NAME OF PROVIDER OR				STREET ADDRESS, 2420 PEMBERTON	I RD		
1				RICHMOND, VA	23233		
THE LAURELS OF U					SERIE DI AN OF CORRECT	TION	(X5) MPLETION
	MMARY STATEMENT OF DEF DEFICIENCY MUST BE PREC TORY OR LSC IDENTIFYING		ID PREFIX TAG		DRRECTIVE ACTION SHOU FERENCED TO THE APPR DEFICIENCY)	JLD 01-	DATE
F 250 Continued	From page 5		F 25	F T	ag 250		
::::	w must provide medica	ally-related social		T)	ident #12 complai	ned of	}
				Kes	th pain during the	survey.	
nracticah	le physical, mental, an	d psychosociai		TOO .	sident #12 had rece	eived	
well-being	g of each resident.		<u> </u>	$ \frac{Rc}{dor}$	ntal services prior	and an	
:			٠	ant	pointment was made	de	
		1 widenced	1	£a1	looging the survey	ı	
This REC	QUIREMENT is not m	et as evidenced	:	TI c	wever resident re	etusea anu	
by:	on resident interview, s	taff interview,		ete	sted his nain was re	esoivea.	
	The section of the court of the	ILICAL FOCOLG		Re	esident will receive	e services	\
				in	the future as need	.ed.	
failed to	provide medically-rela	et practicable		1			ļ
- l-, rolool	wall-haind for two or	29 (001001110		R	esident #6 had der	rtal	
surveys	sample, Resident #12	and 6.		se	ervices prior to sur	vey and	
	vectitud to mi	ovide/obtain timely	,	W	ill be offered serv	ices as	
1. The dental s	facility staff failed to placervices for Resident #	412.		n	eeded in the future	ð.	
dental : The fir	facility staff falled to p services to Resident # ndings include:	0.			All residents needingervices have the pope affected by this	otenna w	
1 Res	sident #12 was admitte	ed to the facility on	:	: :		1	
12/14/ not lim stroke pressi blood hyper	13 with diagnoses that hited to, CVA (cerebral h), HTN (hypertension hure), hyperlipidemia (estream), hemiplegia, cholesteremia.	vascular accident - high blood levated lipids in the depression, and	- a		An audit will be call residents to ide have a need for dethat have not been	ental service	ì
set) v	dent #12's most recent was a quarterly assess assment reference date was coded on the MDS	a) of 3/2/16. Resid	ent	Facility ID: VA0	248 If	continuation she	et Page 6 of 122

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

		S FOR MEDICANE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	DNSTRUCTION	COMP	LETED
ST	ATEMENT (OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A, BUILD	ING		0	,
Αħ	ID PLAN OF	CORRECTION					1	21/2016
			495109	B. WING			0412	2112010
				<u> </u>		ET ADDRESS, CITY, STATE, ZIP CODE		Ì
	NAME OF P	ROVIDER OR SUPPLIER		İ		PEMBERTON RD		
	THELALL	RELS OF UNIVERS	ITY PARK		RIC	HMOND, VA 23233		
	INE LAU	,		ID	L	PROVIDER'S PLAN OF CORRECTION	D BE	(X5) COMPLETION
-	(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL OF DEFITIENT INFORMATION)	PREF	ΊΧ	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
	PREFIX	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	TAG	3	DEFICIENCY)		
	TAG !	KEGGE/(10)-1						
-		The second secon	The state of the s			Any identified residents	will	
	E 0E0	Continued From p	nade 6		250	receive dental services a	lS	
	F 250		JUD GLIO GIODS (Status Score OF 10 Out	i t		indicated.		
		14 - 7° - MDC	manual noculitients that a socie	:		indicated.		
		of 15. The MBO	at the resident's cognition is				^	
		intact.				The NHA will in servic	3	
_						——social services staff on	1 . 1	
		Resident #12's re	ecord documented the resident			providing medically - r	erated	\
1		was under Medic	caid services.	*	:	services to attain or ma	ıntaın	
1				•		the highest practicable		1
		A review of Resid	dent #12's clinical record the following physician notes:			physical, well-being.		
Ì		revealed, in part,	atient) requests visit today r/t			F7 - ,		
		tdoint () ()	tooth "ache X Z uave.			The Social Services Di	rector	ļ
		A	4 Dian. CLacked footil' godio.			will audit residents wit	h need	ļ
	İ	1 1 1	Aine Henrisi addonimiono	1		for services weekly for	. 4	
					:	for services weekly for	, ,	
		ti - thaoba nain	Militae Spoke to bia (banama)	:		weeks to ensure timely	a to	
			ANTALANIN LANDUUN KUUSI UI	1	:	appointments are made) 10 Deguita	Ì
		. 141	~~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	-		maintain well-being.	Xesuns	,
		and plan: Tooth	make defined appears on a make defined appears on a make defined appears on a make defined with family re-			will be reported to the	NHA.	
		Staff to schedul	le) after checking with family re:			Any variances will be		
	1	preferred provide	der "			corrected and continue	∍d	
						education provided.		
		Further review	of Resident #12's clinical record	:		2.3.3.4		1
		مأمسيسا الا	SAV AUTEINA NOISS DE SOUISI SULT	ce :				
	1	notes that evid	enced that resident #12 had			Continued compliance	will be	
		received denta	l services.			manitored through the	7	
		1	to the for Posident #12			facility's quality assur	ance	:
		A review of nur	rsing notes for Resident #12	ed :		program. Additional		\ \
		- 11 10	art, that Resident #12 had received for documented toothache on			education and monitor	ring will	. ;
		ومحفسات والأسا	a, 4971075 1771075			be initiated for any ide	entified	
		- LIDERG: 2/21/	16 3/23/10 3/24/10 3/20/19	:			P.E.	
		3/26/16: 3/27/	16; 4/18/16 and 4/19/16.	:		concerns.		}
	1							
		On 4/20/16 at	10:00 a.m. an interview was			Completion Date:		
			h Resident #12. Resident #14 v	yd5 ;		May 26, 2016		
		s -lhatha	war not be had seem a upings					
		Resident #12	stated that he had seen one on			Facility ID: VA0249 if co	ntinuation s	sheet Page 7 of 122

CENTERS FOR MEDICAR	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	INSTRUCTION	(X3) DAT	E SURVEY MPLETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:				1	c
AND PLAN OF GOTTLES					i	/21/2016
	495109	B. WING		ET ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF PROVIDER OR SUPPLIE	R					
		ļ		PEMBERTON RD IMOND, VA 23233		
THE LAURELS OF UNIVER	SITY PARK		RIG	PROVIDER'S PLAN OF CORRE	CTION	(X5) COMPLETION
SUMMARY S	STATEMENT OF DEFICIENCIES	ID PREF	IΥ	CACH CORRECTIVE ACTION SHO	JULU BE	COMPLETION DATE
	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	
TAG REGULATORY O	R ESO IBENTA PARE					
			r :			
F 250 Continued From	nage 7	F	250			
ALLONG POORIS	of toothache. Resident#14 was	3				
1 - Ludwodhar a	or not he continued to have		:			
l	a tooth Resident #12 stated the		<u>:</u>			-
1	24 to do back and have the footi-		-			
		3_!				
صاحبا الالالا	s and the definish couldn't last par	1 !	:			
	3 5 6 6 6 7 7 M/3C 3 5 K EU WHO HID LIDE					
the confinite	d to have brodiens will no con-	1.				
Resident #12 s	tated that it hadn't bothered him					
too much.						
	intoniow was					
On 4/20/16 at 1	11:40 a.m. an interview was	nit	:			•
conducted with	RN (registered nurse) #4, the ur #4 was asked whether or not the	re :	1			
	econoct for Resident #14. IN The		:			
	AIR DOLLADOW KIN HAT MAD GOVE					_
1 - 11 - 2 - 2 - 2 - 2 - 2	Decident #17 USG Section double		1			•
	hat che thallant ne nau scen a					
. +	and to brovide the documentation	of	:			
	F DVI #1 MAS HUALDS TO LOOKE A	')				1
	- and cratan it the restuctil digit	Τ .		•		
1 to a northing	hack from the visit we wouldn't			-		:
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11_1114	AF GAA BUITEING SIAN WAS IV	ad				•
l la war in a tha	Chian of cale for a featuein time i	IGG				
	nertit visit KN #4 Stateu, ***			•		
should have o	called to follow up." RN #4 ore time to gather information.	:				:
		:				
0= 4/00/16 3	t 12:45 p.m. RN #4 stated that sh	ie				
						:
	stione" RN #4 Was asked to Prov	ride		•		
	SAFAR NOTE HALL HIS LIGHTLY FISH					•
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	no further care reduited. This	#4		1		
				1		
				:		
that the med	lications and treatments are prov	iueu		1	f continuation	sheet Page 80

PRINTED: 05/05/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING . AND PLAN OF CORRECTION 04/21/2016 B. WING 495109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK (X5) PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES ID. CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG F 250 F 250 | Continued From page 8 and that ADL (activities of daily living) are done. Nurses are also responsible to make sure that physician orders are followed and that the resident sees the physician when necessary. RN #4 was asked what is documented when a resident leaves the facility for a consult. RN #4 responded, "The night shift nurse gets the paperwork ready for the appointment and generally the nurses document when the resident leaves the facility. We did not document anything when (name of Resident #12) when to see the dentist." RN #4 was asked what other documentation would be included when a resident goes out of the facility on an appointment. RN #4 responded, "There should be documentation when they return, we would document the time of return and whether or not there are any new orders." RN #4 was asked whether or not this was done for Resident #12, RN #4 stated it was not done. RN #4 was asked whether or not Resident #12 needed to go back to the dentist, RN #4 responded that she did not know. On 4/20/16 at 1:00 p.m. an interview was conducted with LPN (licensed practical nurse) #10. LPN #10 stated that she worked with Resident #12 the day following his dental appointment and that he (Resident #12) had told her that he needed an extraction. LPN #10 was asked whether or not she documented anything or followed up with the dentist that Resident #12 had seen. LPN #10 responded that she had

talked to his (Resident #12's) son about getting another appointment. LPN #10 was asked whether or not she followed up and she stated that she did not. LPN #10 was asked what she should have done to ensure that Resident #12

PRINTED: 05/05/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING C. AND PLAN OF CORRECTION 04/21/2016 B, WING 495109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK PROVIDER'S PLAN OF CORRECTION COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES ID DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG F 250 F 250 Continued From page 9 stated that she should have followed up or involved social services to get Resident #12 the treatment-he-needed. A review of Resident #12's care plan dated 9/1/15 and reviewed on 3/9/16 revealed, in part, the following documentation: "Onset/DC (discontinued) 12/28/15. Problems/Conclusions: Pain: Actual Pain related to cracked tooth. Approaches/Interventions: Administer medications for pain and observe for effectiveness (sig)/side effects and report ineffectiveness to physician." At an end of the day meeting on 4/20/16 at 5:50 p.m., ASM (administrative staff member) #1, the facility administrator; ASM #2, the director of nursing, ASM #3, the regional QA (quality assurance manager) and ASM #4, the regional manager; were made aware of the above findings. ASM #1 stated that she would look for information to determine whether or not anything was documented about Resident #12's dental appointment. A policy was requested at this time for consult appointments. On 4/20/16 at 8:40 a.m. ASM #1 was interviewed. ASM #1 stated, "We are still trying to get documentation on the dental appointment. We know that nothing is documented and we know that follow up was not done."

On 4/21/16 at 9:05 a.m. an interview was

conducted with OSM (other staff member) #2, the social worker. OSM #2 was asked what her role was in regards to dental appointments. OSM #2 responded that she did not get involved with dental appointments unless there was a problem.

PRINTED: 05/05/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING . AND PLAN OF CORRECTION 04/21/2016 B, WING 495109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 250 F 250 | Continued From page 10 responded, "I had no idea about his dental issues. He never mentioned dental issues to me." No further information was presented prior to the end of the survey process. 2. The facility staff failed to provide/obtain timely dental services for Resident #6. Resident #6 was admitted to the facility on 5/7/11

Resident #6 was admitted to the facility of 15/1/11 with diagnoses including, but not limited to:
Bipolar disorder, seizure disorder, Schizophrenia, dementia, heart disease, and depression. On the most recent MDS (minimum data set), a significant change assessment with ARD (assessment reference date) 2/10/16, she was coded as having moderate cognitive impairment for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was coded as having broken teeth.

On 4/20/16 at 8:10 a.m., Resident #6 was observed sitting up in bed in her room. When the resident smiled, the surveyor observed that she had multiple chipped/broken/missing teeth. An attempt to interview the resident about her dental status was unsuccessful due to Resident #6's nonsensical responses.

A review of Resident #6's clinical record revealed a nurse's note written 11/12/15 by LPN (licensed practical nurse) #1. The note stated, in part: "Guest commented that she eats all of her food but that she only has one tooth. RD (registered dietician) made aware and diet downgraded to mechanical soft."

Further review revealed the following note written

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		CONSTRUCTION	(X3) DAT	TE SURVEY		
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AND PLAN OF	CORRECTION	IDENTIFICATION NOMBERS	A. BUILDING			С		
		495109	B. WING			/21/2016	-{	
				REET ADDRESS, CITY, STATE, 2	ZIP CODE			
	ROVIDER OR SUPPLIER			20 PEMBERTON RD				
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	u_uart Health	ny and texture has been	; ;	· ·				
	changed to mech	anical soft due to poor		<u> </u>				
	dentition."							
	E II - movious re	vealed the following note written	1 1					
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	Resident #6's	weight loss, including double als and dietary supplements.	l i	:				
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	luta to dontal	issues REDUINE LOOK HOLLO DOS	1	:				
	(dentist) 3/16/	16 and she had #7 and #26			,	1		
	extracted."		:			<u>:</u>		
	A review of th	e comprehensive care plan for			If continuation	sheet Page 1:	2 of 12	
				Familia ID: VA0249	II COLLEGION	-		

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING . AND PLAN OF CORRECTION С 04/21/2016 B. WING 495109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK PROVIDER'S PLAN OF CORRECTION (X5)COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES ID DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX DEFICIENCY) TAG F 250 F 250 Continued From page 12 Resident #6 dated 2/22/16 revealed, in part, the following: "Alteration in dental status related to: some of natural teeth missing, broken/loose/carious teeth....Dental consults as needed." On 4/20/16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional quality assurance manager, and ASM #4, the regional manager, were informed of these concerns. On 4/21/16 at 8:35 a.m., OSM #2 was interviewed regarding the process for obtaining dental consults for residents. She stated: "I don't really get involved in that. If someone needs a phone number or something, I will get them the number. The nurses do the calling and set the appointments." When shown the above referenced note (2/9/16) and asked what she remembered about Resident #6's dental situation, she stated: "The guest's son contacted me to let me know." She stated that she thought it was the son's job to make the appointment for the resident. She stated: "I gave the son the number." When asked if she followed up to see if the son made the appointment in a timely manner, she stated, "No I didn't. I assumed he would make the call. I gave him the number of a dentist who takes Medicaid and that's the last I heard of it." When asked if she was aware that Resident #6 had been losing weight since November 2015, she stated: "Sometimes I went

to the care plan meetings. But now I don't much anymore." She stated she did not have a memory of the weight loss coming up in any discussions with other staff members. When asked to review her note again and to explain the

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(X3) DATE SURVEY

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Y /	ING	C	OMPLETED
AND PLAN OF	F CORRECTION					04/21/2016
		495109	B, WING			4/21/2010
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
				2420 PEMBERTON RD		
THE LAU	IRELS OF UNIVERSI	TY PARK		RICHMOND, VA 23233 PROVIDER'S PLAN OF	COPPECTION	(X5)
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F 250	Continued From p	page 13	•			
	surveyor (that she	e gave the resident's son the				
		nd what her hole stated there				
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		acked it she shedhiveny				
		andreation Will the residence	ч.			
	shout the rev	sident's dental needs, one state	u.			
	115.1 £1_ mé vini 1 100.	antion it not feally. Per is mil		:		
	probably brough	t it up in an evening meeting."				
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	On 4/21/16 at 8:	45 a.m., LPN #1 was interviewe	su į	•		
	جويب ساكات	AGARC TAY ARKHILLU UGULGI		<u>:</u> :		
		JAMA CNA SIMIRII. VVG UUTT		•		
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	1 -11,	SAS " She stated and work at	~		•	
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	she found out	On 4/21/16 at 11.05 a.m., 6.55		:		•
		4 hour any notes of any		:		1
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	us to get her a	a dental consult."	:	!		:
ļ			1	<u>:</u> :		
	On 1/21/16 at	11:10 a.m., OSM #1 was				•
	intermitation for	agaiding Resident #0 5 dental 5:	atus.			ī
	Cha etated. "	We have been following [the		<u> </u>	If a time setie	on sheet Page 14 of
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CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		C		
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	495109	B. WING	ET ADDRESS, CITY, STATE, ZIP CO	1		
NAME OF PROVIDER OR SUPPLIER			PEMBERTON RD	•		
THE LAURELS OF UNIVERSI	TY PARK		MOND, VA 23233			
		ID ID	DROVIDER'S PLAN OF COR	RECTION	(X5) COMPLETION	
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F 250 Continued From p	age 14	F 250				
regident for some	s time." She stated she did not					
I socil anyone tellit	no her that the restoem was					
having trouble che	ewing due to poor dentition. he had not actually assessed the	· } ;				
She stated that si	ace. When asked about the					
i diam'n comm	ant about the resident	:				
15 twinting ho	r diet due to dental Issues, sile					
l l l l l l l l l l l l l l l l l l l	t thinking this was related to no					
dentition. I thoug	ht she just preferred those look	3				
for some reason.	11					
A review of the fa	acility policy entitled "Dental					
Camilood" reveale	ad in part, the following, the					
facility will provid	e or obtain from an outside	i				
	and twenty-lour (24) hou					
L dont	al carvices to meet the needs of	· ·			ļ	
anab guast if ne	acessary, the facility indat dadio	•				
the guest in mak	king appointments, arranging and from the dentist's office, at	nd				
transportation to	ng guests with lost or damaged					
dentures to a de	entist."					
ì						
No further inforr	nation was provided prior to exi	t. F 278				
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	CCECCMENT	F 210;			!	
SS=E ACCURACY/CO	OORDINATION/CERTIFIED					
	nt must accurately reflect the					
resident's statu	it must according to the					
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A registered nu	rse must conduct or coordinate					
each assessme	ent with the appropriate	:	:			
participation of	health professionals.	1 2 3	:			
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assessment is	completed.	•				
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Each individua	I who completes a portion of the	e :	į			
assessment m	ust sign and certify the accurac	у ОГ				
				If continuation shee	et Page 15 of 12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ENTER	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	riple co	NSTRUCTION	(X3) DATE COMP	SURVEY LETED
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, 2,		, and 0.0	B. WING	_			1/2016
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r= 1 AT1	RELS OF UNIVERSI	TY PARK			IMOND, VA 23233		
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E 278	Continued From p	page 15	F	278			
r 210	that portion of the	assessment.					:
					F Tag 278		
	Under Medicare a	and Medicaid, an individual who					
	in the diviond knowle	indivicerillies a material and			Resident # 4 no Ion	ger resides	
	in i labourantir	, a regineni assessinicii			at the facility.		
		wanny nanahy of flot life that	0		•		
	\$1,000 for each a	noney periods of the statement in a			Resident #9 MDS l	nas been	
		ial and taise statement in a			opened and will be		
	in a side of accessor	nent is subject to a civil incres			and submitted by d	ate of	
	resident assessing	ore than \$5,000 for each				all of	
	assessment.	,			completion.		:
				:	- 44 - BAA FDC 1	- 1	:
	Clinical disagree	ment does not constitute a			Resident #2 MDS 1		i
	material and fals	se statement.			opened and will be	completed	!
					and submitted by d	late of	
		MENT is not met as evidenced			completion.		
		MENT IS NOT THE LAS CARGOTTES	:		1		
	by:	rvation, staff interview, clinical			Resident #13 MDS	S has been	
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		· facility statt talled to complete .	C411		and submitted by	late of	
	to MING /	Minimum Data Sett assessing.	nt :			auto or	
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	ODOCO (Influen	as vaccine () a significant one	iige		resides at the facil	ity.	
		ant with an Arth Maacaamon			! !		1
		e) of 3/5/16 for Resident #4. staff falled to properly code			:		ŧ
		Thinanza Vaccinci di a qualle	rly		1		:
	Section Ouzou	ent with an ARD of 3/21/16 for	:				1
	- 11-440						1
	L. The facility's	staff failed to properly code sect	ilon				
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İ	: (Dahayiar)" Of	a unatterly impo assessment	nin :				
1		4 /4 CC + CC C CC CC CC CC CC					
1		545F talled to 255E55 ally 2004;	ent's		:		
	code Residen	t #2's dental status on the resid	0110		100.100.0010	f continuation sh	eet Page 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	S FOR MEDICARE	& MEDICAID SERVICES	0.00 1411	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
TATEMENT.	OF DEFICIENCIES		(X2) MUL	NING	1 1
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		C
			D MING		04/21/2016
		495109	D. WING	STREET ADDRESS, CITY, STATE, ZIP C	ODE
	PROVIDER OR SUPPLIER			2420 PEMBERTON RD	!
				2420 PENDERSON NA 22222	
THEIAL	JRELS OF UNIVERS	ITY PARK		RICHMOND, VA 23233	RRECTION (X5)
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(X4) 1D	SUMMARY ST	TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL OF IDENTIFYING INFORMATION)	PREF	LIN CROSS-REFERENCED TO THE	APPROPRIATE
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TAG	, time				
		Acquired All Profilements of Fernance	_	070	
E 070	Continued From p	page 16		278	. DC
F 278	Continued Form	e in status MDS (minimum data		All residents with	
ı	significant change	with an ARD (assessment		assessment subm	issions have
	set) assessment	of 2/29/16.		the potential to b	e affected.
	reference date) o		'S	tile prisition	
				An audit of the l	
T				An audit of the i	to will be
	(assessment roded f	for cognition (Section C) and		MDS assessmen	ts will be
	mood (Section E	0).		completed for ac	ccurate coding
				for influenza vac	ccine, dental
	5 The facility Sta	aff failed to correctly code that		status, oxygen th	nerapy and
	Resident #22 Wi	as receiving oxygen therapy on	.\	dashes for section	ons C, D, E,
	the five day adn	JISSION MIDO (HIMINITALI) CONTRA)	\and Q. Any cor	rections Of
	assessment dat	ted 7/28/15.		\and Q. Any con	will be made
				updates needed	A 11 factories
	The findings inc	clude:	on !	and submitted.	All luttle
			iae	MDS assessme	nts will be
			.5-	reviewed accor	dingly to the
			į.	MDS schedule	or as a change
	Reference Date	e) of 3/5/16 to the facility on		in status indica	fes.
	Resident #4 Wa	as admitted to the facility on agnoses that included but were agnoses that included but were	not	III Status maioa	
	12/6/13 with di	blood pressure, arthritis, stroke,	Ī		-1 course
Ì				Regional clinic	al resource
			ata	specialist will	educate MIDS
				department and	d social services
				denartment on	appropriate
				coding and ex-	ceptions for
			ng	using dashes of	on the MDS.
				using dashes c	/AL VACT ::
			, , , , , , , , , , , , , , , , , , ,	_ ~ 1	-ton will audit
	requiring total	gebeugeuge ironi aran	ist :	MDS coordin	ator will addit
	A DI O / G official	ide ot obliv liviliy),	ļ	completed M	OS assessments
}			26.2	for 4 weeks a	nd any identified
			as a of	issues will be	corrected and
	significant ch	ange assessment with an ARD	t the	submitted.	:
				Submined.	
	MDS assess	ment documented the following	iccine		
				·	
1	in the facility	for this year's influenza dome-	D. H93011	Facility ID: VA0249	If continuation sheet Page 17

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

CENTERS FOR MEDICARE	& MEDICAID OLIVERICUA	(X2) MULTI	PLE CONSTRUCTION	COMPLETED
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	G	C 04/24/2016
		B. WING _		04/21/2016
	495109		STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER			2420 PEMBERTON RD	
			RICHMOND, VA 23233	
THE LAURELS OF UNIVERS	IIY PARK			TION (X5) COMPLETION
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PRÉFIX (EACH DE POILE) TAG REGULATORY OR	CY MUST BE PRECEDED BY THE COMMON (INFORMATION)	:		
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į	4 -7	F 2	278	*11 1
F 278 Continued From	page 17		Continued compliance w	All be
a bla > (arrow)	A Skip to Ouzouc, it it illustration		monitored through the	
vaccine not rece	ived state reason		facility's quality assuran	ice
3 Voc> (arro	IM) Collings to Cores .		program. Additional	
influenza vaccine	e received.		education and monitorin	<u> </u>
 A "0" was docu n	e received. nented under Part A indicating nented under Part A indicating		education and mointoin	tified
			be initiated for any iden	HIIOU
"C. If influenza \	/accine not received,		concerns.	
reason:	in this facility during this year's			
1. Resident not	IN this racinty dames		Completion Date:	
influenza vaccir	haldo of the facility.		Complete	
2. Received out	tside of the facility.	:	26 - 26 2016	i
3. Not eligible.	doclined		May 26, 2016	
4. Offered and		1	:	i •
5. Not offered.	btain influenza vaccine due to a	:	:	;
6. Inability to of declared shorts	ane			•
		. 4		
A = (dash) wa	as documented and or passes of indicating that this area was no	iI.		
assessed.		hat :		
·	v of the clinical record revealed t	nat		,
				:
	MAN THE III VACCITIONS	1.		ŷ.
On 4/20/16 at	t 5:10 p.m., an interview was	e		
MDS coordin	ator. When asked what dashes	'l am		
not sure, das	shes are not even an option. This	ed		
means it was	not assessed. To the assessed for		3	
that section	00250B was not about the F	RAI		i ·
Resident #4.	ssessment Instrument) manual (when	1	
(Resident As	SSESSMENT MODALITIONS		- - -	:
completing t	at 6:04 p.m., administration was			:
		ther		* * *
made aware	was presented prior to exit. Was president Assessment Instru		:	
		ıment 📒	:	
The MDS R	cuments the following:			continuation sheet Page 1
Manual) do	Cullianta nto tenestra o	1D: H82911	Facility ID: VA0249	55

CENTERS FOR MEDICARE	1774 DROVIDERISUPPLIENVUIA		CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING _			С
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	495109	B. WING	REET ADDRESS, CITY, STATE,		
NAME OF PROVIDER OR SUPPLIER				2,1 00-1	
	,		20 PEMBERTON RD		
THE LAURELS OF UNIVERS	ITY PARK	RI	CHMOND, VA 23233	S CORRECTION	(X5)
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,	200 18	F 278			
F 278 Continued From p	Jaye 10				
"Coding Instruction	ons for O0250A, Did the	\$ 			
Desident Receive	the influenza vaccine in trib	1	i		
Facility for This Y	ear's influenza Season?		<u>'</u>		
Code 0, no: if the	resident did NOT receive the				
——— influenza vaccine	in this facility during this year's Proceed to If Influenza vaccing	3 :			
Influenza season	L Proceed to B mildoniza vassim		1		
not received, sta	te reason (00250C).	:			
Code 1, yes: if th	the resident did receive the in this facility during this year's	:			•
influenza vaccine	Continue to Date Vaccine				
Influenza seasor	Continue to Date Vaccine	1 1			!
Received (0025	UD).	1			
	ons for O0250C, If Influenza	•			
Coding Instruction	ons to Ouzgoo, it is made				:
Vaccine Not Red	ceived, State Reason as not received the influenza				
If the resident no	as not received the hinderica				
vaccine in this to	acility for this year's Influenza 50A=0), code the reason from the	ne i			
season (i.e., 02	50A=0), code inc reason in since				
following list:	to smith during this year's	!			
Code 1, resider	nt not in facility during this year's				
influenza seaso	on: Resident not in the facility	:			
during this year	's Influenza season.	!S			
Code 2, receive	ed outside of this facility: include	∋r :			
influenza vaccii	nations administered in any other pysician office, health fair, groce	ry			
setting (e.g., pr	lysician omce, neam ran, gross fire etation) during this year's	•			
	fire station) during this year's				
Influenza seas	on. gible-medical contraindication: t	f :			
			<u> </u>		
	a individual allemic reaction to		† -		1
			:		1
eggs or other	munize, or an acute febrile illne	ss			:
order not to Im	wever, the resident should be	!	i		
is present. Ho	wever, me resident ones.	į			
vaccinated if o	contraindications end.	1			
Code 4, offere	ed and declined: resident or	i i			
responsible pa	arty/legal guardian has been hat is being offered and choose	s			•
informed of w	Hat is being unorder and short		; ;		1
not to accept	the vaccine.		:		
Code 5, not o	ffered: resident or responsible ardian not offered the vaccine.				<u> </u>
l harty/legal gu	ardian not offered the vaccine.			If continuation	sheet Page 19

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/21/2016 B. WING 495109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES ΙD CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 278 F 278 Continued From page 19 Code 6, inability to obtain vaccine due to a declared shortage: vaccine unavailable at the facility due to declared vaccine shortage. However, the resident should be vaccinated once the facility receives the vaccine. The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year. Code 9, none of the above: if none of the listed reasons describe why the vaccination was not administered. This code is also used if the answer is unknown." 2a. The facility staff falled to properly code section O0250 (Influenza Vaccine) of a quarterly MDS assessment with an ARD of 3/21/16 for Resident #9. Resident #9 was admitted to the facility on 11/21/14 with diagnoses that included but were not limited to neurosyphilis,* major depressive disorder, altered mental status, chronic pain, and dementia. Resident #9's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/21/16. Resident #9 was coded as being able to understand others for communication and being understood by others for communication. Resident #9 was coded as requiring supervision with transfers, dressing, locomotion, and ambulation; extensive assistance from staff with tolleting, personal hygiene and bathing, and independent with meals.

Resident #9's most recent MDS (Minimum Data

PRINTED: 05/05/2016

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

CENTERO TOR THE	TO A DOUBLE COURT DE CONTRACTOR DE CONTRACTO	,	TPLE CONSTRUCTION	COM	IPLETED
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE/MOLE/ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE/MOLE/ND PROVIDER/SUPPLIE/		a. Buildii	NG		c
AND PLAN OF CORRECTION				i	/21/2016
	495109	B. WING			IZIIZVIO
			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
NAME OF PROVIDER OR SUPPLIE	:R	1	2420 PEMBERTON RD		
			RICHMOND, VA 23233		
THE LAURELS OF UNIVER	OILL FAIR		TROUGER'S DIAN OF CORP	RECTION	(X5)
SUMMARY S	STATEMENT OF DEFICIENCIES	ID PREFI	A COORDECTIVE ACTION S	HOULD DE	COMPLETION DATE
		TAG	^ CONCERPRENCED TO THE A	PPROPRIATE	
PREFIX (EACH DEFINITION OF TAG REGULATORY O	NCY MUST BE FREGLED TO MATION) R LSC IDENTIFYING INFORMATION)		DEFICIENCY		
		:			!
A STATE OF THE STA		E '	278		
F 278 Continued From	page 20	1 4	2,0		
	7/74/46 Section 1/10/20 Hilling 1/20		!		
ا ماه د ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱	MICE ADDIMENTED THE LONGINGS.	1	:		
" " " " L L = " o c) C	tant receive the middines seem				
	this veer's innuenza acason:				
o No≥ (arro	M) SKID to Ouzabet in intrastruction				
	aread ciair leasull	E I			
1 Yes> (arr	ow) Continue to Oozoob, Bate	:			
	na racelvec	:			
	SEATON HANDE PAIL A HUIOGINS				
d - Library influent	za vaccine was not administer our		:		•
"C If influenza	vaccine not received, state				
			i		
1 Resident no	t in this facility during this year's				•
influenza Vacci	ination season.		•		
2 Received ou	utside of the facility.				
3 Not eligible.					
4. Offered and	l declined.	:			
6 Inability to C	bbtain influenza vaccine due to a				
declared short	tage.				
مطلاعت دد -	cahava	1	:		
	documented linger pair o vi	:	·		
section 00250	0 indicating that this area was not		•		
		nt l			
The street months	w of the clinical record revealed that	at	<u>:</u>		
	TO CARRANGINE NATIVI HOU				
antod to	receive the 110 vaccination arms	ıy.	•		:
Live microsture	S Was dated 1/20/15.				<u> </u>
- 400M6 c	FEMILE MEN AND THE PROPERTY OF		•		· ·
تهد احمد السياسي	THE BINEAS THE MIDS COOLUMNESS.				* 1
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	- 4 that Mediuell 48 2 MMA 444		1		•
	al. Cho efaten iliai udolico cii v	100			•
1	Accordment was not according				
			i V		
anaible :	for completific sections of one are	HUL	•		
have a reaso	on why this section was not	1			•
		!			
	at 6:04 p.m., administration was		: ;		
made aware	at 6:04 p.m., administration at 6:04 p.m., administration at the elif the above concerns. No further		(D.) (A.) (C.)	If continuation	sheet Page 21 o
IIIaao alla		100046	Facility ID: VA0249	001,100.0011	-

	CENTERS FOR MEDICARE	& MEDICAID SERVICES	(X2) MULT	IPLE CO	ONSTRUCTION	(X3) DAT	TE SURVEY	
S	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					С	
		495109	B. WING		EET ADDRESS, CITY, STATE, ZIP C		/21/2016	
-	NAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIT C PEMBERTON RD	,002		
	THE LAURELS OF UNIVERSIT	TY PARK			HMOND, VA 23233			
	(X4) ID SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	** Leure auchlie, ie s	esented prior to exit. A bacterial infection of the brain		278				
1	or spinal cord. It u	sually occurs in people who disvolilis for many years. This		· · · · · · · · · · · · · · · · · · ·				
	1 (btained from————————————————————————————————————						İ
	"C (cognitive path	f failed to properly code section erns), D (Mood) and E juarterly MDS assessment with 6 for Resident #9.						
	Set) was a quarte 3/21/16. Resider section B0700 "L communication. under section B0 others for communication dressing, locome sections from	ost recent MDS (Minimum Data erly assessment with an ARD of the first assessment with an ARD of the first assessment with an ARD of the first assessment with an ARD of the first assessment as a supervision with transfers, of the first and ambulation; extensive staff with tolleting, personal thing; and independent with	or \					
	dated 3/21/16 d	(Cognitive Patterns) of the MDS ocumented the following: "Shou or Mental Status (C0200-C0500 - Attempt to conduct interview s"	al G				:	
	C0200, C0300, this assessmer C0600 through	e coded for sections C0100, C0400 and C0500 indicating that was not completed. Section C1000, were also coded with ng that the staff assessment for was not completed.					about Poors 22 of 1	122
	I COOLUITA C STORE			r	Coolity ID: VAN249	If continuation	sheet Page 22 of 1	:==

CENTERS FOR	MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE (CONSTRUCTION	(X3) DA	TE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDE AND PLAN OF CORRECTION IDENTIF		(X1) PROVIDER/SUFFEILINGEN, IDENTIFICATION NUMBER:					C
		495109	B. WING				4/21/2016
NAME OF PROVIDER				242	REET ADDRESS, CITY, STATE, ZIP COD 20 PEMBERTON RD CHMOND, VA 23233	ÞΕ	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD RE	(X5) COMPLETION DATE
F 278 Contir			F2	278			
the fo	on D0100. (M llewing: "Sho anducted?"	ood) of the MDS documented uld Resident Mood Interview	· · · · · · · · · · · · · · · · · · ·				
Dash throu was r D060 that t	es "-" were c gh D0300 ind not complete 00, were also he staff asse bleted.	oded for sections D0100 licating that this assessment d. Section D0500 through coded with dashes indicating ssment for mood was not					
and pres	Frequency) of ence of symphysical behaviors of the symphysical behaviors (s	Behavioral Symptom-Presence ocumented the following: "Note of the second	· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·		
B. V	larhal hahavii	oral symptoms directed toward atening others, screaming at					
1	- "de ofhore-	oral symptoms not directed (e.g. physical symptoms such a ing self, pacing, rummaging"	35		:		
ind	shes "-" were icating that th sessed.	coded for all three prompts lese behaviors were not					: : : : : : : : : : : : : : : : : : : :
Fre res tak	equency) doc sident reject (king medication cessary to accept and well	on of Care Presence and umented the following: "Did the evaluation or care (e.g. bloodwoons, ADL assistance) that is chieve the resident's goals for being? Do not include behavious been addressed					sheet Page 23 of 12
j	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				E	rconunuation	3110ct age 2001 12

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC	INSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		С
	495109	B. WING		04/21/2016
NAME OF PROVIDER OR SUPPLIER		}	ET ADDRESS, CITY, STATE, ZIP CO	DE
			PEMBERTON RD	
THE LAURELS OF UNIVERSI			MOND, VA 23233 PROVIDER'S PLAN OF CORF	RECTION (X5)
(CACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 278 Continued From p	age 23	F 278		
0, Behavior not ex 1. Behavior of this 2. Behavior of this less than daily.	type occurred 1 to 3 days. type occurred 4 to 6 days but			
3. Behavior of this	type occurred dally."			
indicating the ass	cumented for this section essment was not completed.			
E0900. (Presence the following: "Ha	e and Frequency) documented is the resident wandered?			
2. Behavior of thi	xhibited. s type occurred 1 to 3 days. s type occurred 4 to 6 days but s type occurred daily."			
A dach "-" was d	ocumented for this section sessment was not completed.			
conducted with (the social worke responsible for conthe MDS ass	50 a.m., an interview was DSM (Other Staff Member) #2, r. She stated that she was completing sections C, D, and E essments. She stated that			
section was not section C, D, an completed. She	ADS assessment meant that the assessed. She confirmed that d E for Resident #9 was not stated that she had missed it. she uses the RAI (Resident strument Manual) as a reference			
On 4/20/16 at 6	:04 p.m., administration was the above findings. No further presented prior to exit.			

CENTERS FOR MEDICARI	TOTAL PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CC	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG			c
	495109	B. WING			04,	/21/2016
OF SPONISED OF SURDICES			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIEF				PEMBERTON RD		ļ
THE LAURELS OF UNIVERS			RICH	HMOND, VA 23233 PROVIDER'S PLAN OF CORRE	CTION	(X5)
(A4) ID (TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL (LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
			278			
F 278 Continued From	page 24	F 4	210:			
The MDS 3.0 RA	I manual documents the					:
following for sect	ion C, D and E:		:			1
1. "Section C (C	ognitive Patters): Steps for		-			
Assessment:	a regident is rarely/never					
1. Determine if the	ne-resident is rarely/never ally or in writing. If rarely/never					
understood verba	to C0700 - C1000, Staff	:	:			
understood, skip Assessment of N	Aontal Status	1	:			:
o Deviews and	iade item (A1700), [O QELERIIIIG	e if !				•
I wonidont need	de or wants an interpreter in t	110 .				
regident needs (or wants an interpreter, complete	te				
the interview wit	h an interpreter.					
O-d-O por if the	a interview should not be					
-Hamptod hocal	use the resident is faithy/never					
dorotood or a	n interpreter is needed but not					•
available. Skip t	o C0700, Staff Assessment of					
NA in Ctature						
Code 1 yes if t	he interview should be attempt	ed !				:
handure the res	sident is at least sometimes					
ilaata ad Mari	hally or in writing, and If an	-1 &- ·				:
interpreter is no	eded, one is available. Froces	a to	ŧ			:
L CO200 Repetiti	ion of Three Words.					
OOFOO Cumma	ary Score (Cognitive Status)	20				:
Cada DD Jinah	le to complete interview. II (a) "	5				
resident choose	es not to participate in the BIMS	ے, ص				
(b) if four or mo	ore items were coded 0 becaus	·C	;			
the regident ch	ase not to answer or yave a					
nonsensical re	sponse, or (c) if any of the BIM	-				
Items is coded	with a dash. core does not mean the BIMS v	was				
Note: a zero so	be incomplete, a resident had	to				i
: 1 n mot to	anewar or aive completely	1				
: cnoose not to	sensical responses to four or n	nore				1 1
11						
items.	ctions for Section C0600. (Staff	t :				
i Association of O	if Cognitive Status)					1
Code 0 not if	the RIMS was completed allu					1
accord hetwes	an ()() and 15. Skip to Casoo.	ż				:
Code 1 ves: I	f the resident chooses not to		 	<u> </u>		heel Page 25 g

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 04/21/2016 B. WING 495109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK PROVIDER'S PLAN OF CORRECTION COMPLÉTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 278 F 278 Continued From page 25 participate in the BIMS or if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response. Continue to C0700-C1000 and perform the Staff Assessment for Mental Status, Note: C0500 should be coded 99. 2. Coding Instructions for D0100. (Mood) Code 0, no: if the interview should not be conducted. This option should be selected for residents who are rarely/never understood, or who need an interpreter (A1100 = 1) but one was not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV®). Code 1, yes: if the resident interview should be conducted. This option should be selected for residents who are able to be understood, and for whom an interpreter is not needed or is present. Continue to item D0200, Resident Mood Interview. Coding Instructions for D0300. (Mood Total Score) Steps for Assessment After completing D0200: Add the numeric scores across all frequency items in Resident Mood Interview (D0200) Column 2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview. The maximum resident score is 27 (3 x 9). Coding for D0500. (Staff Assessment for Mood) Alternate means of assessing mood must be used for residents who cannot communicate or refuse or are unable to participate in the PHQ-9© Resident Mood Coding for D0600. (Staff Assessment for Mood

Total Score)

 $30.(3 \times 10).$

Add the numeric scores across all frequency items for Staff Assessment of Mood, Symptom Frequency (D0500) Column 2. Maximum score is PRINTED: 05/05/2016

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION C 04/21/2016 R. WING 495109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG F 278 F 278 Continued From page 26 . 3. Coding Instructions for Section E0200 (Behavioral Symptoms), E0800 (Rejection of Care) and E0900 (Wandering) Code 0, behavior not exhibited: if the behavioral symptoms were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7 days. Code 1, behavior of this type occurred 1-3 days: if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days. Code 2, behavior of this type occurred 4-6 days, but less than daily: if the behavior was exhibited 4-6 of the last 7 days, regardless of the number or severity of episodes that occur on any of those days. Code 3, behavior of this type occurred daily: if the behavior was exhibited daily, regardless of the number or severity of episodes that occur on any of those days." 3. The facility staff failed to assess and accurately code Resident #2's dental status on the resident's significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/29/16. Resident #2 was admitted to the facility on 4/9/99. Resident #2's diagnoses included but were not limited to: malignant neoplasm (cancer) (1) of cheek mucosa (tissue) (2), hemiplegia (paralysis) (3), dysphagia (swallowing disorder) (4) and aphasia (disorders caused by damage to the part of the brain responsible for language control) (5).

Resident #2's most recent MDS (minimum data

PRINTED: 05/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	COMPLE		
AND FLAM OF	Oomas				04/21/	2016
		495109	B. WING _	STREET ADDRESS, CITY, STATE, Z		2010
	PROVIDER OR SUPPLIER			PCOBL		
IHE LAU				RICHMOND, VA 23233 PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(CAOU DEDIC!ENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		THE APPROPRIATE	DATE
		07	F 2	78		
F 278	Continued From p	page 21	, -			
	with an ARD (asse	essment reference date) of		i		
	2/29/16, coded the	e resident's cognition as being . Section G coded Resident #2				
}	severely impaired	nsive assistance of one staff with				
	as requiring exter	sfers, dressing and personal —				
	- bed mobility, train	G further documented the		1		
	hygiene. Section	supervision and set up help with	1	:		
	resident required	coded Resident #2 as not		:		
	boving abnormal	mouth tissue, cavities, broken		:		
	tacth inflamed/bl	eeding gums, or loose teem.	:			
	L0200G "Dental-	none of the above" was coded.		:		
	FNT (ear nose a	nd throat) consult notes for	:			
	Resident #2 reve	aled notes dated 4/30/15 and		:		
	= 5/4//45 with a do	ocumented diagnosis of a				
ļ	- canoarous ulcera	ative lesion of the left buccal	1.		:	
	· (obook) mucosa	for which Resident #2 underwen	ıt			
		S The FNI notes documented				
	the wound was t	partially reopened on 7/14/15 and)			
	the wound was v	vell healed on 4/19/16.				
	On 4/20/16 at 10):15 a.m., an interview was				
	- anducted with I	PN (licensed practical nurse) #4	2			
	seconding oral at	esessments. LPN #Z was asked	1			
	to describe Resi	ident #2's teeth. LPIN #2 Stated				
,	the recident har	oral cancer and her teeth were				
	kind of discolore	ed. LPN #2 stated the resident	Ì			
	was missing sol	me teeth.		:		
		2.45 nm observation of	į	· 1		
	On 4/20/16 at 1	2:45 p.m., observation of eeth was conducted with LPN #2				
	Resident #2's te	s obtained from the resident). The	he:	:		:
	(permission was	m teeth presented with an off	ļ			
	resident's σοπο	color. Some back teeth were	i	1		:
	missing and so	me fillings were observed. INC				
	-hima or oracke	were observed. Resident #4 3 t	ор			:
	chips or cracks	with an off white yellowish color				
	Como block dis	coloration was also noted.				
	Miceing tooth w	vere observed in the back and rig	ght]			<u></u>
	TANGOUNG FOOR IN				If confinuation sheet	Page 28 c

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	NO LUITO E	CONSTRUCTION	(X3) DA	TE SURVEY	
CTATEMENT (OF DEFICIENCIES	I/V4\ DROVIDER/SUPPLIER/GUA		CONSTRUCTION	co	MPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION	A. DOILDING			C	
		495109	B. WING			4/21/2016	-
	TOTAL OD BUIDDING			REET ADDRESS, CITY, STATE, ZIP C	ODE		
	ROVIDER OR SUPPLIER			20 PEMBERTON RD			
THE LAU	RELS OF UNIVERSI	TY PARK	RI	CHMOND, VA 23233	DDECTION!	(X5)	-
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	V SHOULD BE	COMPLÉTION DATE	
			F 278				
F 278	Continued From p	age 28	F 2/0!				
	seems aide of the re	sident's mouth. No chips or	:				
	cracks were obse	rved. All observations were	:	1			
	confirmed with LP	10 #2:	:				-
<u> </u>	On 4/20/16 at 5:1	0 p.m., an interview was	:				
	a direct and with RI	N (redistered hurse) #3 (une					Ì
-	* and * * * dinotor	RN #3 Was asked it resident					
	#2 had any issue:	with her teeth/mouth. RN #3 / knowledge." RN #3 was asked		•			
	stated, "Not to my	s information to code section L					
1	COLLEGIO DA	#3 stated she obtains up					
	antation fr	om nursing ancumentation and					
1	r bacruc	Highe When Collibication in Paris					
	interview with res	sidents. RN #3 was asked if she e inside of Resident #2's mouth					
	- I - antirmed cl	had not. At this time, this mo					
1	ware made oware	of Resident #Z'S FIVE COllows					
	i and thin or	irvovor's onservations of the					l
	regident's teeth	KV #3 MSS SHOMH Section F of					
	Resident #2's M	DS and confirmed the snot accurate. RN #3 stated she	э ¦				Ì
	references the F	Al (resident assessment	:				
	instrument) mar	nual when completing MDS					
	assessments.						
		annovimately 6:00 nm ASM	i i				
	On 4/20/16 at a	pproximately 6:00 p.m., ASM staff member) #1 (the		:			
	landadrotor) C	ad ASM #7 The difector of					
	nursing) were n	nade aware of the above findings	3.				
			1				
	The CMS (Cen	ters for Medicare and Medicaid					
	Services) RAI r	nanual documented:					
	"SECTION L. C	DRAL/DENTAL STATUS		•		4	
	しょしょん ずんばん ほん	m is intended to record any usin	al :			•	
	problems prese	ent in the 7-day look-back period	•				
	L0200: Dental						
	DEFINITIONS						
	CAUTY			T	If continuation	sheet Page 29	of 12

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	C	MPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG		c
		495109	B. WING		0	4/21/2016
				STREET ADDRESS, CITY, STATE,	ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			2420 PEMBERTON RD		
THELAII	RELS OF UNIVERSI	TY PARK		RICHMOND, VA 23233		
1116 570		10m http://www.new.new.new.new.new.new.new.new.new.		PROVIDER'S PLAN O	F CORRECTION	(X5)
(X4) ID PREFIX TAG	(** A OU DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE AC	OTION SHOULD BE OTHE APPROPRIATE	COMPLETION DATE
	Manage Ma					
F 278	Continued From p	age 29	F	278		
, 2, 5	A tooth with a disc	colored hole or area of decay				
!	that may have det	oris in it.		:		
	BROKEN NATUR	AL TEETH OR TOOTH	:			
	EDAGMENT			:		
	Manufaran cavify	tooth broken off or decayed to				
	gum line, or broke	en teeth (from a fall or trauma).				
	ORAL LESIONS	-f there a red white vellow or		•		-
	A discolored area	of tissue (red, white, yellow, or				•
	darkened) on the	lips, gums, tongue, palate,				
	cheek lining, or the ORAL MASS	noat.				
	A awallon or raise	ed lump, bump, or nodule on an	y ⁱ			
	oral surface May	be hard or soft, and with or				
	without pain.					
	HI CED		:	<u>:</u>		
	Mouth sore, blist	er or eroded area of tissue on				
Ì	any oral surface.					
	Item Rationale					:
	Health-related Q	uality of Life			•	
	Poor oral health	has a negative impact on:				•
	 quality of life 					
1	- overall health	10				•
]	- nutritional statu	in identify periodontal disease the	nat İ		•	
	-Assessment ca	or cause systemic diseases at	nd :			
	conditions such	as aspiration, mainutrition,	5			
	nneumonia enc	locarditis, and poor control of				:
	diabetes.					
1	Planning for Ca	re		•		:
	neb prizzassa.	tal status can help identity		:		1
	regidente Who n	nay be at risk for aspiration,	٠	;		:
	mainutrition, pn	eumonia, endocardilis, and poo				1
ļ	control of diabe	ites.		:		
	Steps for Asse	ssment	:	***		:
	1, Ask the resid	dent about the presence of	į	:		
	chewing proble	ms or mouth or facial	4 1	•		•
	pain/discomfor	tent family, or significant outer	i	:		
	Z. ASK the lesit	sident has or recently had dentu	res	:		
	WHELIE HE TES		100044	Facility ID: VA0249	If continuation	sheet Page 30 of 1

	S PUR MEDICALLE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	INSTRUCTION		MPLETED
STATEMENT	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			c
ANDIDITO	. •	ļ					1
		495109	B, WING				4/21/2016
	VOED OD CURRUISE				ET ADDRESS, CITY, STATE, ZIP CO	DDE	
NAME OF F	PROVIDER OR SUPPLIER				PEMBERTON RD		
THE LAL	JRELS OF UNIVERSI	TY PARK		RICH	HMOND, VA 23233		
7112			ID	L	PROVIDER'S PLAN OF COR	RECTION	(X5) COMPLETION
(X4) ID PREFIX	THE ALL DEDOCKNO	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
TAG	REGULATORI OR	200 (22.17)					
	1		!				
E 070	Continued From p	age 30	F	278			
F 210	COMMINGE FOR P	dent or family/significant other					
	or partials. (If residence	sident recently had dentures or		1			
	reports that the re	do not have them at the facility,		:			Ì
	ask for a reason.)	do ligatinave atom en an					·
	ask for a recident b	nas dentures or partials, — —		·			· · ·
† ·	avamine for loose	a fit. Ask him or her to remove,					
	and examine for a	chins, cracks, and cleanliness.					
	Pernoval of denti	res and/or partials is necessary	•				
	1226 Struppho and	essment.					ļ
	 Conduct exam 	of the resident's lips and oral					
	dontrir	ree or nartials removed, II	:				!
	and allowed a	s light source mai is audquate to					
į	:aliza tha bac	k of the mouth, visually observe	:				
	d fool oll oral s	untaces including hps, guille,					
	termina polata m	nouth tions, and theek insing,	;	:			
	. Check for abnort	mai mollin (ISSUE, autivitua)					
	i the ar inflama	d or hieeding quitis, the					
	econographouid	TISE HIS OF HEL GIOVED HINGOID TO	:	:			
•	adagustaly feel t	ror masses of 100se teens	1				
	E If the recident	is unable to sell-report, inch	. !				
	-backer him or t	her while eating with dentales of	1	:			
	nartials if indica	ited, to determine it chewing	<u> </u>	÷			
Į	blome or mol	oth hain are bresent.	i	!			
ļ	Oral examina	tion of residents who are					
	uncooperative a	and do not allow for a thorough	ıa				
	oral exam may	result in medical conditions being	'9 ; - :				
	missed. Referra	al for dental evaluation should be	-		1 3 1		
	considered for t	hese residents and any resident	•		1 1 1 1		
Ì	who exhibits de	ntal or oral issues.	į				•
	Coding Instruct	nons , broken or loosely fitting full or	!		•		:
	Check LUZUUA	if the denture or partial is chipp	ed,				<u>:</u>
	partial denture:	anable, or loose. A denture is					:
	cracked, unclea	if the resident complains that it	is		1		•
	coded as loose	ure visibly moves when the	!		!		:
	loose, the defit	his or her mouth, or the denture	e ;		1		
	resident opens	ne resident tries to talk.	:		1 1		:
	Chach Lobude	B, no natural teeth or tooth	Ì				;
	frogment(s) (e	dentulous): if the resident is					1 15 54 -54
i i	Haumonia) (C	어, 보이 말하다 하다 가 있는 그 <u>~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ </u>				If confinitation	sheet Page 31 of 1

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY MPLETED
STATEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			С
		495109	B. WING		OTATE		/21/2016
NAME OF P	ROVIDER OR SUPPLIER			2420	ET ADDRESS, CITY, STATE, 2 PEMBERTON RD	ZIP CODE	
THE LAU	RELS OF UNIVERSI			RICI	HMOND, VA 23233 PROVIDER'S PLAN OF	F CORRECTION	(X5)
(X4) ID PREFIX TAG	ALL ALL APPRIATENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION DATE
			· 	278			
	4 4 10	s all natural teeth or parts of	1 : :	270			
	Object 1 02000 3	abnormal mouth tissue (ulcers,	: 	<u>!</u>			
	I Iion io no	ons): select if any ulcer, mass, oted on any oral surface.					
	check L0200D, or natural teeth: if an Check L0200E, i loose natural teeth swollen, or bleedithey readily move with a fingertip. Check L0200F, discomfort with any pain in the ma	bevious or likely cavity or broken by cavity or broken tooth is seen inflamed or bleeding gums or h: if gums appear irritated, red, ing. Teeth are coded as loose if when light pressure is applied mouth or facial pain or hewing: if the resident reports touth or face, or discomfort with unable to examine; if the cannot be examined, none of the above: if none of bugh F is present" mation was presented prior to extion was obtained from the .nih.gov/medlineplus/cancer.htm	it.				
	(2) This information website: https://www.nlm.002264.htm	ition was obtained from the					: : :
	website: https://vsearch	ation was obtained from the .nlm.nih.gov/vivisimo/cgi-bin/que oject=medlineplus&v%3Asource .ndle&query=hemiplegia	ery- s=				:
	(4) This inform	ation was obtained from the	:		English ID: VA0249	If confinuation :	sheet Page 32 of 12

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/21/2016 B, WING. STREET ADDRESS, CITY, STATE, ZIP CODE 495109 NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES 1D DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG F 278 F 278 | Continued From page 32 https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/querymeta?v%3Aproject=medlineplus&v%3Asources= medlineplus-bundle&query=dysphagia (5) This information was obtained from the https://www.nlm.nih.gov/medlineplus/aphasia.htm website: 4. The facility staff failed to ensure Resident #13's quarterly MDS assessment with an ARD (assessment reference date) of 3/18/16 was correctly coded for cognition (Section C) and mood (Section D). Resident # 13 was admitted to the facility on 7/20/15 with diagnoses including, but not limited to: neurogenic bladder, hyperlipidemia, paraplegia, atrial fibrillation, and high blood pressure. The most recent Quarterly MDS assessment with an ARD of 3/18/16 coded Resident #13 on Section C (Cognitive Patterns) the resident's brief interview for metal status as (-) out of 15, indicating Resident # 13's cognition interview was not completed [per MDS coordinator, RN (registered nurse) #3]. Review of Section B "Hearing, Speech, and Vision" in Section B-0700 (Makes Self Understood) was coded as "0," Understands; and in Section B0800 (Ability To

Understand Others) was coded as "o" -

Understands. Review of Section D (Mood) was also coded as (--) (again indicating that the

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
STATEMENT (OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		NG	С
AND PLAN OF	- CORRECTION				1
		495109	B, WING_		04/21/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 2420 PEMBERTON RD	IP CODE
THE LAU	RELS OF UNIVERS	TY PARK		RICHMOND, VA 23233	CORRECTION (X5)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE DATE
,,			<u> </u>		
F 070	Continued From p	hade 33	F 2	278	
F 2/8	Coullinger Light H	# 2\			:
	Coordinator, RN #	<i>t</i> 3).			:
	The most recent	complete MDS, a quarterly		:	
	antwith	VBH (SSSSSMENFIELDIGLELICE			
<u> </u>		TORRESTEEL # 10 OIL 110			
	PIMS (hrief interview for thetal status		i	:
	4 F = 4 A F 1 A D	ndication Resident#100			
	it was a contra	66t RAMEW () 3660000 P) .		:
1	i militarina Shaach	and Aisini in accion p area	' !		Ì
	(Makes Self Und	erstood) was coded as "0,"			
	Understood; and	in Section B0800 (Ability To			
}	Understand Other	ers) was coded as "0" -	•		
	Understands.				:
	An Interview Was	s conducted on 4/20/16 at 10:30)		
}		2 INC CHARLETT MIDD WITH ALL		:	
	A DECIMAL TO A COMPANY	tar Decideni # (2 was ievicione	1	4	
	= 1 120	DNI # 3 etated 3 (1851) () Would		·	
	- 11 1 1 1 - 4 4 1	INTORVIAINS MATE TOLUDITIDICICA	,		
	طغلم سلسلت مراز ومست	'Y CVGISH WILKEL POTIONSION DA.	.,		
	Contion Cland S	Section D. RN # 3 luling states	4	•	
	she uses the RA	AI (Resident Assessment nual as a reference for complet	ing i	1 2	
	instrument) Ma	nual as a reference to compres			:
ļ	MDS.		1		
	During the end	of day interview on 4/20/16 at		<u>!</u> :	
					<u>!</u> ·
			#2,		
Ì	i the dispotor of t	nurging ASIVI # 3, the regioner		;	;
}	- Carabby Assurat	nce Manager, and Asim # 7 476		:	1
		Mare Intorried of these		× .	<u> </u>
		thic time a remuest was made "			· ·
	interview the s	ocial worker when she came to			· · · · · · · · · · · · · · · · · · ·
ļ	work in the ma	grang.			·
	On A104146 of	8:55 a.m. OSM (other staff			
	1 1 40	the coold wilker was illerive	ved		:
	مطلعت السائدة	ANAVATREFERENCES SUFFICIONS OF A	-		: :
	- was asked wh	at the dashes mean. OSM # 2	<u> </u>		If continuation sheet Page 34 of 122
1				Eacility ID: VA0249	

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	ONSTRUCTION	(X3) DA	MPLETED	
STATEMENT (OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			С	
AND PLAN OF	CONTRACTOR					0.	1/21/2016	
		495109	B. WING			The second secon	1/2 1/2010	
	THE OD SUPPLIED				EET ADDRESS, CITY, STATE, ZIP	JODE		Ì
	ROVIDER OR SUPPLIER				D PEMBERTON RD			- }
THE LAU	RELS OF UNIVERSI	TY PARK		RIC	:HMOND, VA 23233			
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1D		PROVIDER'S PLAN OF CO	DRRECTION	(X5) COMPLETION	N
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL OF THE STREET OF TH	PREF	·ίΧ	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	E APPROPRIATE	DATE	
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC	3	DEFICIENCY)		
IAG	:			<u> </u>				
	L .		-	070				}
F 278	Continued From p	age 34	۲	278				
1 2/0	144-4 it moo	at the interview has not been		i				ļ
			i					}
}	LL the orth	PERIODIAL TO THE PERIOD OF THE						
1	I - I - foronce cy	AP LISEU IU COMPIETE RIC MICA	·	<u> </u>				
	assessment and	she stated the RAI Manual.						
	No further inform	ation was provided prior to exit.		:				1
}				:				ļ
	For Cognition the	e CMS (Centers for Medicaid	d .	:				}
	and Medicare Se	ervices) RAI manual documente						į
	the following:							
	- 10 DAL(Can	ters for Medicaid and Medicare			:			
	· o · - Dooido	of Accessment Institutions						Ì
		THE R. MIDO TERRE OF STORES	: ;		* *			
	**C0200-C0500*	Brief Interview for Mental Status	S !					
	(BIMS)		•		1 1			1
	Otems for Acces	sment						
	4 Determine if t	he resident is rarely/never			•			
	donatood vert	vally or in Writifid, it raissymbotor						
į	understood, Skil	o to C0/00 - C1000, Stan	:		•			!
ļ	Assessment of	Mental Status	:		<u>:</u>			
	Coding Instruct	ions	be ·				-	
	Record whether	r the cognitive interview should l	:					
	attempted with	ne resident. ne interview should not be	:					
	11	WISE THE PESIDENT IS LOUDING TO						
	i understood or s	an interpreter is needed but not	- 7					
1	understood or a	to C0700, Staff Assessment of	!					
	na Lab Chadusa		1					
}	· Ondo 1 yes if	the interview should be attempt	ea		1			
	the course the re	seident is at least sometimes	;		1		;	
	وتستيدات والأراث	abally as in Wisting and It all	d to		1			
	interpreter is N	eeded, one is available, i 10000	ų io		•		:	
ļ	C0200, Repeti	tion of Three Words.	1		1			
	į		i		5 			
	Coding Tips	sical responses should be code	ed !				•	
		SIGN TESPONSES STORIGES SE	_ { ·		1			
	as zero.				= #91D: \/AD249	If continuation	sheet Page 3	5 DT 12

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(73)	COMPLETED	
AND FLAN O	001012011011						C	
		495109	B. WING				04/21/2016	-
NAME OF F	ROVIDER OR SUPPLIER	3			REET ADDRESS, CITY, STATE, Z	.IP CODE		
	RELS OF UNIVERS				0 PEMBERTON RD CHMOND, VA 23233			
THE LAU				KIC	PROVIDER'S PLAN OF	CORRECTION	(X5)	1
(X4) ID PREFIX TAG	TEACH DECICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	COMPLETION	
F 0.30		25 and 25	F	278				
F 2/8	Continued From p	topping the interview before it is						
	complete:	topping the litter view policies in te		:				
	- Stop the intervie	ew after completing (C0300C)						ļ
	"Day of the Week	c" if:						\perp
-	all responses hav	/e-been nonsensical-(i.e., any	:					
ļ	response that is t	unrelated, incomprehensible, or formative with respect to the		:				
	item being rated)	. OR	1	:				
	there has been n	o verbal or written response to	:					
	any of the question	ons up to this point, OR		:				
	there has been n	o verbal or written response to up to this point and for all others	l.					
	: some questions	given a nonsensical response.	,					
	. If the inter	view is stopped, do the following	g:					
	Code - dash in (C0400A, C0400B, and C0400C.						
Ì	Code 99 in the s	ummary score in C0500.						1
	Code 1, yes in U	:0600 Should the Staff Mental Status (C0700-C1000) b	e ^f					
	Conducted?							
ļ 1	Complete the St	aff Assessment for Mental						
	Status							
	For Manad The C	CMS RAI manual documented th	ie i					
	following:	NIO TOTAL MAINE A COUNTY OF THE STATE OF THE						
								,
	"SECTION D: N	100D	ĺ					
	Intent: The item	s in this section address mood	:					
	distress, a serio	ous condition that is d and undertreated in the nursing	g				•	
	home and is as	sociated with significant morbidi	ty.					
	It is particularly	important to identify signs and					:	
	eymptoms of M	good distress among nursing nor	ne ;				i	
	residents becau	use these signs and symptoms	:				Ē	
	can be treatable		!					
	D0100: Should	Resident Mood Interview Be	1					
	Conducted?		7					
	Coding Instruct	tions			1			
	Code 0, no: if	the interview should not be	<u> i · · · · · · · · · · · · · · · · · ·</u>	<u> </u>		If continuation	sheet Page 36 o	

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
STATEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:					С
		495109	B. WING		EET ADDRESS, CITY, STATE, ZIP CO		4/21/2016
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITT, STATE, ZIF OF PEMBERTON RD	56 ∟	
THEIAU	RELS OF UNIVERSI	TY PARK			HMOND, VA 23233		
11160 607 100		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION	RECTION	(X5) COMPLETION
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		The state of the s	_	070			
F 278	Continued From p	age 36	}-	278			
	conducted. This o	ption should be selected for		1			:
	I aidonto who are	rarely/never understood, or					
	who need an inter	nreter (A1100 = 1) but one was		<u> </u>			i
	not available. Skip	to Item D0500, Staff	:	1			
	Assessment of Re	e resident Mood (PHQ-9-OV®). e resident interview should be					
	·Code 1, yes: If the	option should be selected for		:			
	conducted. This c	e able to be understood, and for					
ļ	on intorpre	ter is that needed of is breschit.					:
	Whom an interpre	D0200, Resident Mood Interview	٧				
	(PHQ-9©)	50200, 111			_		
	·						
}	: D0200: Resident	Mood Interview (PHQ-9©)		:			Ì
	Coding Instruction	ns for Column 1, Symptom	. :				
	O-d-O not if re	sident indicates symptoms lister	d !	:			ľ
	are not present e	enter 0. Enter 0 in Column 2 as		:			
	wall						
	Codo 1 vos: if r	esident indicates symptoms		:			
	listed are preser	it enter 1. Enter 0, 1, 2, or 3 m		:			
	a lime a Cymr	stom Freduency.					
	. Code 9 no res	ponse: If the resident was unab	e ·		:		ļ
		complete the assessificing	:				
		ensically and/or the facility was					- 1
Ì	i unable to compl	ete the assessment, Leave					
Ì	Column 2, Sym	otom Frequency, blank.					:
	Coding Instructi	ons for Column 2. Symptom					i :
	Frequency	dent's responses as they are	:				
	Record the resi	ess of whether the resident or the	е				
	their	the the symmidil to Suite iii. 9			:		
	-that than man	4 Futher evaluation of the online	cal		•		: :
	rolevance of rel	norted symptoms should be					
	lamad by the	reenansinie Cilniciali.	1				
	Cada O nover	UL J. USA. IL IIIG LESIGERE HOLOGIO	S		1		i
	that he or she	has never or has only experience	ed				:
	ill montom o	n 1 day					:
	Codo 1 2-6 da	avs (several days): It the residen	ıt				: :
	indicates that h	ne or she has experienced the				15	sheet Page 37 of 12
	Trotograp I. a.	Event ID: H	82911	F	acility ID: VA0249	It continuation	SHEEL FAGE 31 OF 12

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	0.03 143 115	TIDLE C	CONSTRUCTION	(X3) DAT	E SURVEY	
CTATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COV	MPLETED	
AND PLAN OF	FCORRECTION	IDENTIFICATION NO.	A, BUILD				C	
		495109	B, WING				/21/2016	
	OD CLIDBLIED		<u>' </u>		REET ADDRESS, CITY, STATE, ZIP COD	E		1
	PROVIDER OR SUPPLIER		İ		O PEMBERTON RD			
THE LAU	IRELS OF UNIVERSI	TY PARK		RIC	CHMOND, VA 23233 PROVIDER'S PLAN OF CORRE	CTION	(X5)	1
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COUNCE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	100to be	COMPLÉTION DATE	-
F 278	Continued From p	page 37	F	278				
1 270	symptom for 2-6 o	days. /s (half or more of the days): if	:				; ;	
	the resident indica	ates that he of she has					:	+-
	- 0 1 2 42 44 de	246 (UESKIV-6A6LA-A9A)-11-14-6						
	resident indicates the symptom for	s that he or she has expendition	ג					
i.	D0300: Total Sev Coding Instruction	ne	i		:			
	ic	CHCCESSITIIV COMDICTED II THE	it .					
	1 + 7 of the Q if	ed the frequency responses of a lems on the PHQ-9©.						
	ic	HANCY IS NIANK TOLD OF HIGH			i !			
	u II. – intomi	lew is deemed NOT complete. core should be coded as '99' and	d					
	Total Severity So	ment of Mood should be			4		•	
	المصاحبيات		A .					
	Enter the total	score as a two-digit number. The core will be between 00 and 27	:					
	or "99" if sympt	com frequency is blank for 3 or	:					
	(amali				· :			
	o Condata	vill calculate the Total Severity illed instructions on manual					:	Ì
	Lud-Haga an	d avaminies see Appolium E.					-	
	PHQ-9© Total S	Severity Score Scoring Rules"	:				:	
			1				1	
		or restable compaths and that			:			
		staff failed to correctly code that was receiving oxygen therapy or	1 1				:	
	the five day ad	mission MDS (minimum data se	et)		!		:	
	assessment da	ated 7/28/15.	:				;	!
	Posident #22 \	was admitted to the facility on	:				!	
	فالمستحد عاملات	PARAMARA ON 1/30/19 WILL	,					
Į.	the second the	t included but were not limited to disease, atrial fibrillation (an	J.					
	anemia, lung (beat) and heart failure.				f continuation	sheet Page 38 o	of 122
í	LIESAUIGE EIGHT				10.343.0040	i comunuaudh	SHOOLI AGO OO .	

	CENTER	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
S	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		<u> </u>	i i	C	
			495109	B. WING	STREET ADDRESS, CITY, STATE, ZI		/21/2016	
	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 21 2420 PEMBERTON RD	1 OODE		
ļ		RELS OF UNIVERSI	TY PARK		RICHMOND, VA 23233			
	INC LAU			 JD	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	CORRECTION	(X5) COMPLETION	
	(X4) ID PREFIX TAG	ALCOHOLD TO THE MO	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE	
-	F 278	Continued From p	age 38	F 27	78			
			ost recent MDS, a five day an ARD (assessment reference					
ļ		- L-L-N -5 7/20/16 C	oded the resident as having a lew of mental status) of 15 out					
	·	car indicating th	a regident was codiffication in trace					
		a a a also doily doc	igions The resident was dodou		:			
	ļ Ī	- living except for e	tance with activities of daily eating which the resident could					
		: do independently	after the meal tray was				ļ	
		prepared.		:				
		signed on 7/21/1 HUMIDIFIED 3I (ysician's orders dated and 5 documented, "OXYGEN: liters)/min (minute) via nasal stic prongs that fit in the nose) a shortness of breath)."	ıs			:	
	-	Review of the nu	rse's notes from 7/21/15 to nted on multiple occasions that receiving oxygen via nasal		· : :			
			lent #22's MAR (medication		:			
		administration re	ecord) documented, OATGER. a nasal cannula; as needed for Start 7/21/15" The record did n	ot			·	
		evidence docun	nentation that oxygen had been	 	1			
		used.		-	;		:	
	\	Review of the r	esident's care plan dated 7/22/1	ວ	:		i	
			COPD (chronic obstructive case), 7/22 O2 (oxygen) 3L PRN	:	•		:	
		(as needed) + '	via Chab. (commons boarne	-			;	
		airway pressure	e) @ NIGHT.				•	
		Review of the f	five day assessment MDS dated	:	i E		•	
			ion O titled "Special Treatment, nd Programs" documented unde			14	sheet Page 39 of 12	
-	+				C114-1D: \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	n continuation i	21,000, 490 000, 1-	

PRINTED: 05/05/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER. A. BUILDING AND PLAN OF CORRECTION C 04/21/2016 B. WING 495109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX DEFICIENCY) TAG F 278 F 278 Continued From page 39 "Respiratory Treatments C. Oxygen therapy. Check all that apply." The box for the oxygen therapy was blank. An interview was conducted on 4/21/16 at 10:34 a.m. with RN (registered nurse) #3, the MDS coordinator. When asked who was responsible for completing section O, respiratory treatments, RN #3 stated, "The MDS coordinator does that." When asked how the information was collected to complete that section, RN #3 stated, "From the notes, the orders, hospital record, the MAR and TAR (treatment administration record)." When asked what time period she used for the look back period to collect the data, RN #3 stated, "Fourteen days since it's an admission." When asked to review the respiratory therapy section of the five day MDS and explain what the blank box indicated, RN #3 stated, "That they didn't get it (oxygen)." RN #3 was asked to review the nurse's notes from 7/21/15 to 7/29/15 documenting that the resident was receiving oxygen therapy. When asked if that the resident should have been coded on the MDS for oxygen therapy, RN #3 stated, "Yes." When asked if she had any idea why it did not get coded, RN #3 stated, "I do not." When asked what policy the MDS coordinators used to complete the MDS RN #3 stated, "The RAI (resident assessment instrument)." On 4/21/16 at 11:05, ASM (administrative staff

aware of the findings.

member) #2, the director of nursing was made

No further information was provided prior to exit.

*CPAP, or continuous positive airway pressure, is a treatment that uses mild air pressure to keep

PRINTED: 05/05/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A, BUILDING AND PLAN OF CORRECTION 04/21/2016 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 495109 NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES ID DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG F 278 F 278 Continued From page 40 people who have breathing problems, such as sleep apnea </health/health-topics/topics/sleep apnea/> http://www.nhlbi.nih.gov/health/health-topics/topic F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET F 281 SS=D PROFESSIONAL STANDARDS F Tag 281 The services provided or arranged by the facility must meet professional standards of quality. Resident #14 received orders from physician services during survey for tube feeding This REQUIREMENT is not met as evidenced to be at 50mls/hour. Based on observation, staff interview, facility document review and clinical record review, it All residents receiving tube was determined that the facility staff failed to feedings have the potential to follow professional standards for one of 29 be affected by this practice. residents in the survey sample, Resident #14. The facility staff failed to transcribe a verbal order The DON and ADON will in for tube feeding from a nurse practitioner to the service licensed staff on electronic medical record for Resident #14. guidelines for medication orders to include verbal The findings include: orders. Resident #14 was admitted to the facility on 4/7/16 with diagnoses including, but not limited to: history of a stroke, chronic obstructive pulmonary disease, Bipolar disorder, and heart disease. The resident had not been in the facility long enough for an MDS (minimum data set) to be submitted. A review of his admission nursing assessment

dated 4/8/16 revealed that the resident had difficulties understanding and being understood by others. The assessment revealed that Resident #14 had a PEG (Percutaneous endoscopic gastrostomy tube *) tube in place.

PRINTED: 05/05/2016 FORM APPROVED OMB NO 0938-0391 (X3) DATE SURVEY

CENTERS FOR MEDIOAINE	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	COMPLETED
STATEMENT OF DEFICIENCIES	IDENTIFICATION NUMBER:	A. BUILD	ING	C
AND PLAN OF CORRECTION				04/21/2016
	495109	B. WING		
			STREET ADDRESS, CITY, STATE, ZIP COD	Æ
NAME OF PROVIDER OR SUPPLIER	-		2420 PEMBERTON RD	Ì
			RICHMOND, VA 23233	
THE LAURELS OF UNIVERSI	IY FARN		- SOUISERIS PLAN OF CORR	ECTION (X5)
	A DEFICIENCIES	ID.	E CONTRACTOR ACTION S	
		PREF TAC	"\	PROPRIATE
PREFIX REGULATORY OR	LSC IDENTIFYING INFORMATION)	1770	DEFICIENCY)	
IAG :				\
			0.04	
F 281 Continued From p	page 41	· -	281	j
		:	The Unit Managers	s will
1 2 44546 - 202	0 p.m., Resident #14 was		complete an audit	of residents
			complete an audit	J_ 100100100
		d ,	with tube feed orde	irs to
			ensure they are rec	erving — — — — —
	Theoryalling on tree, to an ex-	0	prescribed amount	and rate.
			Prosorrous and	
a.m. and 11:40 a	bed with the tube feeding at the	ie :	m DONI - Joseph	mee will
similar position in same rate of 50	mis/hour		The DON or design	11
		:	continue to audit a	ili new
,	dent #14's clinical record	:	orders and admiss	ions
		y 🕴	5x/week for 4 week	eks to ensure
			accuracy. Any var	riances will
		l/h ↓	accuracy. Arry van	antinuing
teeding [name of	and 300 ml water flush q 4 h		be corrected and o	
(milliliters/flour)	ana 552		education provide	a. The
(every four hour			results of these at	idits will be
h and the	resident's April 2016 MAR		reported to the D	ON.
A review of the	ministration record) revealed no	}	reported to the	
_flain	Ardar THE HUST LOOP TO STAND	on		
	AANTAN FINEIGHOOOMS			c
the MAK docum	24 hours at 50 ml/hour."		Continued comp	nance will be
			monitored through	gh the
O- MADIAE at a	11:40 a.m., LPN (licensed pract	ical	facility's quality	assurance
			program. Addition	าทลโ
		rate !	program. Additiv	onitoring will
	TIME NO CISION IN THE INTERNAL SECTION OF THE	;	education and m	Omornig viii
			be initiated for a	ny identified
	- Aarod ne Staleu. Na vo, ''		concerns.	
			: 	
			Completion Dat	e'
			Completion Dat	
			May 26, 2016	
			:	
cnecking a lui	at are in the computer." LPN #2	2	:	1
				:
				:
had not been	that the rate had changed from	50		If continuation sheet Page 42 of
L did not know-	U IOL DIOLI GAS INSTITUTE	. 100044	Facility ID: VA0249	II communication sheet ago siz or

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	ONSTRUCTION	(X3) L	COMPLETED
STATEMENT OF AND PLAN OF C	DEFICIENCIES ORRECTION	IDENTIFICATION NUMBER:					,
AND PLAN OF C	CHALCHON		1				C
		495109	B. WING				04/21/2016
		1	2007		EET ADDRESS, CITY, STATE, ZIP	> CODE	
NAME OF PRO	OVIDER OR SUPPLIER				D PEMBERTON RD		}
THE LAURE	ELS OF UNIVERSI	TY PARK		RIC	HMOND, VA 23233		
			ID	<u> </u>	PROVIDER'S PLAN OF C	CORRECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	CETICIENIC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAC		(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	HE APPROPRIATE	n +==
:			i	1			
		40	F	281			
F 281 C	Continued From p	page 42	•	2201			
Ì n	nls/hour to 40 mls	s/hour.					1
;		- DN (registered purse)					
	On 4/20/16 at 1.4	5-p.m., RN (registered nurse)					
#	#1 was interviewe	ed regarding the process for bal order to the electronic	<u> </u>				
1 :	and Chartesta	24. "YOU TAKE OT USE OLDER TOO	ı İ	:			
1	record. She state	der] into the system. You print i	ŧ i				
ľ		H ADAS STRICON NON HIS	-	:			
	www.dontothor	harmacy " When shown he	1				
	-L roforance	y verbal otoet for president a cit	•				
	above-letele "I mi	ust not have seen this. I did not					
	take it off. That's	s my error."					
 							•
	A review of Resid	dent #14's care plan dated					
1	4/20/16 revealed	d, in part, the following: "Tube			•		
	feeding as order	ed."					•
l							
1	On 4/20/16 at 5:	50 p.m., ASM (administrative					
	/ (t h - r) #	4 the administrator. Activity of the	, ,				
	· Business of nurch	na ASMERS, THE REGIONAL GUALLY					
ļ	THE PROPERTY OF THE PARTY	ager and ASW #4, the regional					
	manager, were	informed of these concerns.					
1			. :				
į	On 4/21/16 at 1	0:25 a.m., ASM #3 provided the	nr :				
ļ	.111	Acoumon' Animen (Julius)1190 1			•		
	Madiagtion Ord	ers " She stated, We leter to	-				
	11.1 NOV OC OL	ir hrotessiotiai Sidiluatu Vi	in :		<u> </u>		
ì	· · · · · · · · · · · · · · · · · · ·	TIAM OF THIS BOCUITION TO VOCIOUS	111				
	part, the followi	ng: "New Verbal Orders: The	v l		İ		
	nurse documer	nts a complete order received by	y				
i i	telephone or in	person on the appropriate	!		:		
1	pharmacy appr	oved formThe nurse must	- :		 - -		
	indicate the pre	escriber's name giving the order	е				
	and the license	ed nurse accepting/recording the					*
ļ .	order. The nur	rse will sign the order in the	he		t .		:
}	appropriate sp	ace on the verbal order formT	İ		•		•
}		only accept orders written on			•		
	pharmacy app	roved forms/systemsIf a urse practitioner writes an order	in				
	physician or nu	TESE DI ACTITION OF WINCO	H82911		Facility ID: VA0249	If continuation	on sheet Page 43 of

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/21/2016 B. WING. STREET ADDRESS, CITY, STATE, ZIP CODE 495109 NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK PROVIDER'S PLAN OF CORRECTION (X5)COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X4) ID TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) PREFIX TAG F 281 F 281 | Continued From page 43 the Facility, a nurse in the Facility transcribes or enters the complete order onto the medication or treatment administration record or electronic medical records system." According to Fundamentals of Nursing, Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. Be sure to look for order duplications that could cause your patient to receive a medication in error...." No further information was provided prior to exit. *PEG tube - "Percutaneous endoscopic gastrostomy tube - a tube placed in the stomach for the purpose of temporary or permanent nutrition." This information is taken from the website www.nlm.nih.gov. F 282 F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED SS=D PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced Based on observation, resident interview, facility document review, and clinical record review, it was determined that the facility staff failed provide care in accordance with the written plan of care for three of 29 residents in the survey If continuation sheet Page 44 of 122

PRINTED: 05/05/2016 FORM APPROVED

CENTERS	S FOR MEDICARE	& MEDICAID SERVICES	(X2) MULT	TIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY _ETED
OTATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	NG		С	}
AND PLAN OF	CORRECTION						1/2016
		495109	B. WING		EET ADDRESS, CITY, STATE, ZIP CODE	0.112	
MANUE OF B	ROVIDER OR SUPPLIER			STRE	PEMBERTON RD		
			1		HMOND, VA 23233		
THE LAU	RELS OF UNIVERS			KIC	PROVIDER'S BLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) DE	COMPLETION DATE
	And the state of t					•	!
E 000	Continued From p	page 44	F	282	F Tag 282		
F 202 '	Conditued Florident	ts #11, #6, and #1.					
			± .	1			Ì
ļ	1. The facility sta	ff failed to follow the written plan					
	of care for the tre	eatment of resident a 110			Resident #11 has a pressu		
<u> </u>	pressure_ulcers.				reducing surface in place		
	a The facility of	aff failed to follow Resident #6's			the wheelchair. Rest peri-	ods	ļ
	2. The facility su	vide needed dental services.	İ		are being offered. The		
			!		pressure ulcer has resolve	∋d.	•
	The facility s	taff failed to apply a fleece					
Ì		n Resident #1's right arm when neelchair as directed in the care		:	Resident #6 had dental	_	
	seated in her wr	#1 was observed without the			services prior to survey a		
	fleece pad in pla	ace for two days.			will be offered services a	S	
	Heece bad 11 kg		,		needed in the future.		
		li ido)			Resident #1- A physician	1'S	
	The findings inc				order was written to		
	1 The facility s	taff failed to follow the written pla	an		discontinue the fleece		
	of care for the	treatment of Resident #11's	į		protective pad. The care		
	pressure ulcers	S.			has been updated to refle	ect	
	•		į		this.		
}	D: dont #11 v	was admitted to the facility on			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	المطاهنين مهنمسي	LANDON TO THE PROPERTY OF THE	not		All residents have the	or this	
					potential to be affected by	y mis	
	aspiration pne	umonia, neurogerno biaddo. arra	: :		practice.		
	history of uteri	ne cancer.				andit	- 1
	The most room	ent MDS (minimum data set)			The Unit Managers will	ave	
			an		residents that currently h	.avc	!
		STORANCE MAIR OF MAIN TO SOCIOS.	ne		pressure ulcers, dental		!
					services, and protective		
Ì			ns.		equipment to ensure car	5 Joot	:
	was capable	of making daily cognitive desired	/e		plans are written and ref	100l 4-d	:
		SANA AT MINITE STALL LIGHTED OF A 14.			current care being provi	aeu.	i _:-
	her activities	of daily living except eating in w	hich		If con	tinuation sh	neet Page 45 of
	THE ACTIVITION	Event ID	: H82911		Facility ID: VA0249 \ If con		

AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			COMPLETED
	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING		С			
		495109	B. WING	3		04/21/2016
100					TREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PRO	VIDER OR SUPPLIER				2420 PEMBERTON RD	
THE LANDS	LS OF UNIVERS	ITY PARK			RICHMOND, VA 23233	,
ILE FWOKE					PROVIDER'S PLAN OF CORREC	TION (X5
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F 282 C	ontinued From p	page 45	F	282	The DON and ADON v	vill in
	he required set u	ip assistance. In Section M -			service licensed staff or	J :
S	kin Conditions, t	he resident was coded as	-		written care plans, writi	
h	aving one Stage	il pressure ulcer and one	:		goals and utilizing the	eare to
- u	ınstagable - deep	o tissue injury wound.			communicate the care e	
,					resident receives along	
	stage II pressur	e ulcer is described as partial				
tl tl	hickness loss of	dermis presenting as a shallow red-pink wound bed, without			updating the care plan	or any
C	open uicer with a	e yellow, tan, gray, green or			changes in resident's	
Į S	Blondu (1011-Algor	rally moist, can be soft, stringy			condition.	:
	ord mucinous in	texture). May also present as an	.		;	
	and mucinous in ntact or open/rur	otured blister. (1)	!		The Unit Managers wil	l audit
:			1		new admissions and ne	ew
,	A deep tissue inju	ury if a nonblanchable purple or			orders 5x/week for 4 w	
1	maroon discolora	ation of intact skin that may			ensure any changes are	
1 :	indicate damage	to the underlying tissue. (2)				
Į.	Daview of the co	morehensive care plan dated,	d i		on the care plan. The re	
	4/12/16 docume	inted, "Problems: Actual impalie	ч		will be reported to the	DON.
	skin integrity rela	ated to Sacral Wound." The	a !		Any variances will be	
	"Approaches" do	ocumented in part, "Measure are	-		corrected and continue	ed
	weekly and dock	ment it's characteristics in the assistance to reposition			education provided.	•
	skin log. Provide	s needed." The care plan			<u></u>	:
	documented "P	roblem: Potential for Impaired	:		Continued compliance	will be
1	ekin integrity r/t	(related to) decline in function an	ıd		monitored through the	
	mobility incontin	nent episodes, current skin	:		facility's quality assur	:
	breakdown and	diagnosis." The "Approaches"				arro
3	documented in t	part, "Limit the time sitting in			program. Additional	
] .	chair " The com	prehensive care plan dated,			education and monitor	
1	4/14/16 docume	ented in part, "Problem: Actual			be initiated for any ide	entified
į	impaired skin in	tegrity related to heel wound."	۾ ا		concerns.	:
1	The "Approache	es" documented in part, "Measur	Ŭ			
	area weekly and	d document its characteristics."			Completion Date:	
ļ		as observed on 4/19/16 at 12:03	. [May 26, 2016	· :
	Resident #11 W	as observed on 4/19/10 at 12:00 a.m. in her wheelchair. A resider	ıt		1414, 20, 2010	
	p.m. and 3:32 p	onducted with Resident #11 on			1	:
	Interview was c	p.m. The resident stated, "My	!		•	
	hottom is sore	and has been sore since got	•			

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED
		495109	B, WING		04/21/2016
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK		5	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OLD BE COMPLETION [
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		DEFICIENCY)	
	:		F 28		
F 282	Continued From p	age 46	F 20,	<u>4</u> !	
	here. They did cha	ange the treatment today."		!	:
ļ	The resident was	observed on 4/20/16 at 12:49	<u> </u>		· · · · · · · · · · · · · · · · · · ·
	n m sitting in her	wheelchair. The speech	_,		
	therapist was wor	king with her.		:	
	An observation w	as made of Resident #11's	•		
	- seeral wound and	theel wound on 4/20/16 at 1:30		:	
	n m with the resid	dent in bed with LPN (licensed		į	
ŀ	inractical nurse)#	11 and LPN #12. The sacruin	1		
1	aniad throp on	ien areas. The areas were	_		
	· magaurad by the	facility statt as: 1 X .5 Cm, .5 X /	5	1	
	icm and 1.6 x 6 €	cm. When asked wily the aleas			•
	wore not measur	ed prior to today (the day of	!	!	
	abconvation of the	e Wound) LPN #11 stated, She			
	had so many one	an areas so we didn't measure			•
	thom all "IPN #1	11 was asked now stall could le	11	:	
	if the wounds WA	re healing if no measurements		:	
Ì	word boing obtail	ned IPN #11 stated, Well, II	:		
}	there are so mar	wareas, how am I to measure	:		
	4ham 2" \Mhan 25	ked about measuring the neel	1		•
	- wound 1 PN #11	stated. "I can only go by what i		•	;
-	- and each week (n Fridays, I glant do the illiual			:
	- coconement " A	fter the observation was			•
-	completed IPN	#12 asked Resident #11 II sile			:
		iff her hottom, and she stated,			
	"Voc that would	he great," When the resident	V		
	was asked if she	e normally takes a rest every do	y :		
	in bed, she state	ed, "No."	1	•	
				1	:
		hadruad on 4/21/16 at 8:16	į į		
	Resident #11 wa	as observed on 4/21/16 at 8:16 elchair. The resident was asked	l if		
	a.m. in her whe	eichair. The resident was asked	off		
	she had been o	ffered to go back to bed to get of			
	her bottom, in the	ne afternoons prior to 4/20/16.			· :
	Resident #11 st	ated, "No, the first time was		!	!
	yesterday (4/20	/16). It's actually the first time	0		:
	they (facility sta	iff) ever suggested I go to bed to			
	get off my botto	ян.		if on	ofinitation sheet Page 47 of

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 04/21/2016 B, WING STREET ADDRESS, CITY, STATE, ZIP CODE 495109 NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES ID DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG PREFIX TAG F 282 F 282 Continued From page 47 Review of the "Pressure Ulcer Record" dated 3/28/16, documented, "Description - Stage II sacrum slight opened." No measurements were documented. It did document no undermining, odor, or drainage. The color was documented as "red." Under the heading, "Length/Width/Depth in cm (centimeters) was documented, "UM (unmeasurable)." For each weekly measurements on 4/2/16, 4/8/16 and 4/15/16, a "UM" was documented under this column. Review of the "Pressure Ulcer Record" dated, 3/28/16, documented, "Description - (L) (left) heel, soft, boggy, red, purple." The "Stage" documented, "DTI (deep tissue injury). No measurements were documented. It did document no undermining, odor or drainage and the color was documented as, "red, purple." Under the heading, "Length/Width/Depth in cm (centimeters) was documented, "UM." For each weekly measurements on 4/2/16, 4/8/16 and 4/15/16, a "UM" was documented under this column. Review of the "Nursing Admission Assessment" dated; 3/29/16 at 1:16 a.m. did not reveal any documentation on the pressure ulcers. The nurse's notes dated 3/28/16 through 4/19/16 were reviewed. On 3/28/16 at 3:48 p.m., it was documented, "Guest has 2 skin issues noted." There was no other documentation regarding the pressure ulcers. An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 4/20/16 at 1:58 p.m. When asked if a pressure -ulcer, described as a Stage II should be If continuation sheet Page 48 of 122

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN O	F CORRECTION	DENTIFICATION NUMBER:	A. BUILDING		С			
		495109			The second secon	/21/2016		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 2420 PEMBERTON RD RICHMOND, VA 23233	ZIP CODE			
		ATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF	F CORRECTION	(X5)		
(X4) ID PREFIX TAG	(EACH DESIGNENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION DATE		
- 000		10	· F 28	2		•		
F 282		age 40		Rem 1				
 	would depend on v	2 stated, "If it's measureable. It where it's located anatomically, e it to tell you that answer."	:	1		:		
	. World have to see	e it to tell you that anower.	<u>:</u>					
	An interview was	conducted with ASM #3, the		<u> </u>		<u> </u>		
	regional QA (quali	ty assurance) manager, on				:		
	4/20/16 at 2:04 p.	m. When asked if a Stage II				:		
	pressure area sno	ould be measured, "ASM #3 en asked if a deep tissue injury	:	1		:		
	should be measur	red, ASM #3 stated, "I would."						
	An interview was	conducted with CNA (certified						
	nursing assistant)	#8 on 4/21/16 at 12:21 p.m.						
	When asked wha	t a care plan is, CNA #8 stated,	•					
1	"It's the plan of tre	eatment for a guest." When	•					
	asked if there any	thing on the care plan that		:				
1	should be followed	d for a resident with a pressure ited, "In those incidences we						
	always lay them o	down after lunch." When asked it	f					
	she looks at the	care plan, CNA #8 stated, "No,						
	it's in the chart."							
		and the death I DN #12 on						
	: An interview was	conducted with LPN #12 on p.m. When asked what a care				+		
	9/21/10 at 12.24	stated, "It's how you implement				:		
	the care in order	to follow through and have an	:					
	: outcome for the t	resident." When asked now the	1					
	information on th	e care plan is communicated to	1	· · · · · · · · · · · · · · · · · · ·		<u> </u>		
	the CNA caring to	or a resident, LPN #12 stated,	:					
	"we give them re	eport." When asked who is roviding this information to the	1					
-	CNA 1 PN #12 s	tated, "The nurse. Honestly, the	y					
	add things to tho	se care plans and don't tell us."	i			1		
	The English molley	y, "Interdisciplinary Care Plan"		:		: 		
	I ne tacility policy	olicy: It is the policy of this facility	/			:		
	to develop an inf	terdisciplinary care plan for each	!					
	: guest that includ	les measurable goals and time		:				
	frames directed	toward achieving and maintainin	ıg '		If	ant Dags 40 of		
		# t ID. Upg	044	Facility ID: VA0249	If continuation she	abiraye 49 of		

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/21/2016 R WING STREET ADDRESS, CITY, STATE, ZIP CODE 495109 NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE 1D SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG F 282 F 282 Continued From page 49 each guest's optimal medical, physical, mental and psychosocial needs...Procedure: 2. The interdisciplinary care plan will: a. incorporate identified problem areas. b. incorporate risk factors associated with identified problems. c. build on the guest's strengths. d. reflect treatment goals and objectives in measurable outcomes, e. identify the professional services that are responsible for each element of care and frequency of services provided. f. Prevent decline in the guest's functional status and/or functional levels, g. enhance the optimal functioning of the guest by focusing on a rehabilitation program." According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders...' The administrator was informed of the above concern on 4/21/16 at 12:15 p.m. (1) This information was obtained from: Centers for Medicare & Medicaid Services; Long-Term Care Facility Resident Assessment Instrument User's Manual; Version 3.0 July 2010, pages

M-15, M-18, M-2.

(2) This information was obtained from the

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 04/21/2016 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 495109 NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG F 282 F 282 Continued From page 50 ml/tileshop_pmc/tileshop_pmc_inline.html?title=C lick%20on%20image%20to%20zoom&p=PMC3&i d=2697592_cia-4-269f1a.jpg 2. The facility staff failed to follow Resident #6's care plan to provide needed dental services. Resident #6 was admitted to the facility on 5/7/11 with diagnoses including, but not limited to: Bipolar disorder, seizure disorder, Schizophrenia, dementia, heart disease, and depression. On the most recent MDS (minimum data set), a significant change assessment with ARD (assessment reference date) 2/10/16, she was coded as having moderate cognitive impairment for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was coded as having broken teeth. On 4/20/16 at 8:10 a.m., Resident #6 was observed sitting up in bed in her room. When the resident smiled, the surveyor observed that she had multiple chipped/broken/missing teeth. An attempt to interview the resident about her dental status was unsuccessful due to Resident #6's nonsensical responses. A review of Resident #6's clinical record revealed a nurse's note written 11/12/15 by LPN (licensed practical nurse) #1. The note stated, in part: "Guest commented that she eats all of her food but that she only has one tooth. RD (registered dietician) made aware and diet downgraded to mechanical soft." Further review revealed the following note written by OSM (other staff member) #1, the registered If continuation sheet Page 51 of 122

PRINTED: 05/05/2016

STATEMENT	S FOR MEDICARE OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DA	TE SURVEY MPLETED		
		495109	B. WING				4/21/2016		
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK				2420	EET ADDRESS, CITY, STATE, ZIP O PEMBERTON RD HMOND, VA 23233	CODE	DE.		
(X4) ID PREFIX TAG	SUMMARY ST.	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE	ON	
F 282	dietician, on 12/2/	age 51 15: "Diet has been liberalized y and texture has been anical soft due to poor	F ·	282					
	by the nurse prac #6] states difficult swallowing. Order review revealed representationer actual	vealed the following note written titioner on 12/11/15: "[Resident y chewing, no difficulty ered dental consult." The record to evidence the nurse liy ordered the consult, and riew the nurse practitioner during unsuccessful.							
	on 2/9/16 by OSI (sic) family is loo looked at. Gues	vealed the following note writter M #2, the social worker: "Guest king to have residents (sic) teet t has Medicaid and I provided a hit manager for [name of local and make an appointment."	h .						
	following note w 3/18/16: "Weigh self-restricting d	clinical record revealed the ritten by the nurse practitioner on the loss over several months due liet to fruit and cottage cheese sues. Brother took her to DDS and she had #7 and #26	n to						
	A review of the Resident #6 dat following: "Alter	comprehensive care plan for red 2/22/16 revealed, in part, the ration in dental status related to: teeth missing, arious teethDental consults as	·						
	-toff mambar):	s:50 p.m., ASM (administrative #1, the administrator, ASM #2, t ing, ASM #3, the regional qualit	he y	. <u> </u>	W. S. VACA40	If continuation	sheet Page {	52 of 12	

DEPARTING CENTER!	S FOR MEDICARE	& MEDICAID SERVICES	OVO MUII	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
	NE DEFICIENCIES			ING	ì	Į.
AND PLAN OF CORRECTION		IDENTIFICATION			l l	C
		10.5100	B. WING			/21/2016
		495109		STREET ADDRESS, CITY, STATE,	ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			2420 PEMBERTON RD		-
				RICHMOND, VA 23233		
THE LAU	RELS OF UNIVERS			THE STREET BY AND	F CORRECTION_	(X5) COMPLETION
	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID PREf		THOM SHOOLD HE	DATE
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			i			
	·	E2	F	282		ļ
F 282	Continued From p	page 52		:		
	assurance manag	ger, and ASM #4, the regional	:			
	manager, were ir	nformed of these concerns.				}
<u> </u>		35 a.m., OSM #2, the social	ì	,		
			for			
			,			į
						ì
			'n	÷		
	the above refere	enced note (2/9/16) and asked	4_1 :			ļ
	what she remen	nbered about Resident #6's del	ntai	•		Ļ
	situation, she st	nbered about Nestdone he ated: "The guest's son contact	.ea			
Ì						
			O1		•	
	the resident. S	he stated: "I gave the son the	ae if			
\			JC 11	•		
				•		
	manner, she st	rated, "No I didn't. I assumed h	of a			
Ì		tes Medicaid and that's the last then asked if she was aware the		:		
				•		
	Resident #6 na	ad been losting weight since 15, she stated: "Sometimes I w	ent .	÷		
\			uch	* :		Ì
				; •		ļ
				;		į
			1	· ·		
Ì						
						:
ļ	phone numbe	er) and what her note stated (the	ai 	:		; ;
				1		
	II PN #11. she	e stated: "Oh. Well, maybe it v	vdə !'m			
ļ				:		;
		** F *21K BY ID 11 (C GUY 11 BY \~ \~ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		•		
				:		÷ •
			stated:	:		
	- - son about t h	e resident's dental needs, she		Facility ID: VA0249	If continuation	n sheet Page 53 of 122

DEPART	MENT OF TILABITE	& MEDICAID SERVICES			NCTDICTION	(X3) DATI	E SURVEY	
STATEMENT OF DEFICIENCIES					NSTRUCTION	COM	IPLETED	
STATEMENT	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		1	c \	ŧ
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		Adjourned	_	000			Ţ	
E 282	Continued From p	page 53	i	282				
F 202	11 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	ntion it not really. ILEN #11					Ì	
	"Now that you me	it up in an evening meeting."		:				i
								ı
	On 4/21/16 at 8:4	5 a.m., LPN #1 was interviewed					<u> </u>	
		SOOK TOT ONIZINI (U UDING)	<u> </u>	= :			:	
				:				
		A COMPETIBLE OFFICION OF	Ι. :					
}		WAS ULLUSTED OF THE COLUMN CO. LICE.						į
	حائصت ا	compaires of the language. One	·					
	() It the doct of	our residents are on Medicular	ż					Ì
	*	CANADEINIA IOI CAIIIIIU IIIV	;					1
	the second coff	ina un transportation (1997)		Ì				Ì
}								1
				į				-
ļ	the first time I'm	seeing this. It's just a note.	:	:			:	1
	don't see an ord	ler." When asked what she pout Resident #6's dental consul	t i					- }
İ	remembered ab	n extraction on 3/16/16, she					:	
ł								
ł			: :					- {
			t				:	- }
	1 1 1 1 1 1 1 1 1	Ch alvin b at 11.00 a.m.		:				ļ
					:			
\	information (JULI KUOM MIIN II IOOK OO IOWA	r		1		!	į
	us to get her a	dental consult."	÷		!			}
Ĭ			2)		i !			
	On 4/21/16 at	11:05 a.m., RN (registered nurse	=) '					
ļ			į		I			
		1445te 63th HAIL 0110 314199			1		: !	
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							!	
}	1 1 1 116	'AMARANI' HEELS LO GOOGO " " "						
	,	a cratell illal life cale Pierrie			e B		¥	
}	guide, and ide	entifies the possible needs a have. She stated that it guides have.	the ¦					
							:	
					•		i i	
ł	She stated the	at the direct care starr (in this esponsible for implementing this	part :		· · · · · · · · · · · · · · · · · · ·		about Page 54 d	<u></u>
— 	 nurses) are re 	Sapor railore rail			Eacility ID: VA0249	if continuation	sheet Page 54 of	. ~

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/21/2016 B. WING 495109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 282 F 282 Continued From page 54 of a care plan. A review of the facility policy entitled "Interdisciplinary Care Plan" revealed no information specific to following a resident's care plan. No further information was provided prior to exit. 3. The facility staff failed to apply a fleece protective pad on Resident #1's right arm when seated in her wheelchair as directed in the care plan. Resident #1 was observed without the fleece pad in place for two days. Resident #1 was admitted to the facility on 6/10/14 with diagnoses that included, but were not limited to, CVA (cerebral vascular accident - a stroke), HTN (hypertension - high blood pressure), obesity, hyperlipidemia (elevated lipids in the blood stream), diabetes, sleep apnea and expressive aphasia (difficulty speaking). Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/10/16. Resident #1 was coded on the MDS as having a BIMs (Brief Interview for Mental Status) score of 7 out of 15. The MDS manual documents that a score of 7 indicates that the resident's cognition is severely impaired. A review of Resident #1's clinical record revealed a care plan dated 6/18/15 documenting, in part, the following entry: "Onset: 7/7/15. Problems/Conclusions: Skin: Potential for impaired skin integrity related to

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PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	COMPLETED		
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THE LAU	RELS OF UNIVERSI	TY PARK		RICHMOND, VA 23233	a conscioni	(X5)		
		TEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	ION SHOULD DE	COMPLETION DATE		
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F 282	Continued From p	page 55	,	:				
ļ	:	activities of daily IVING) autivity.						
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<u> </u>	· · · io · Chin will r	emain littact to trove on any						
		m V RAVIEWED SIZE IV.	<u> </u>					
		CANTIALISE LISCOC CIDEN	ı	•				
	protector to R (rig	ght) elbow. Start 7/7/15."	:	•				
			es :	·				
	Resident #1 was	observed on the following date in her wheelchair with a lap tra	av					
	and times sitting	arm on and there was no fleed	e					
		widht binnwi A/ (3) to be 1.55						
	protector on her	11:25 a.m.; 4/20/16 at 4:30 p.r	n.			:		
	•							
	E de emporioss C	of Resident #1's clinical record				\ :		
	-1I- DOS	Copyrigidad Otable Sheeri	į	:		:		
}		SAME "GOTTURE DELICIO LECTURA IN						
		tallaused orner was uccurrent	ed:					
	THE LOCALIAGE	A BARATA ACTIVE NECESTATION	• :	•				
Ì								
		CONTRACTOR OF THE VIOLENCE OF	,					
	night) Telepho	ne order from (name of project	ilan) ;					
	taken by (name	of nurse)."						
	•		ė.					
	A review of Re	sident #1's TARs (treatment	2016					
	administration	record) for the month of April 2						
		irt, the following treatment; ery shift for Start: 2/1/16 3:57 a	am					
						;		
		~~~~~						
				:				
				:				
				<b>;</b>				
Ì		SER ORGINATION SHIP OF TREE	, ,	:				
	- initialad	I that the tieece protector was	UI)	1		į		
	Resident #1's	right elbow on dayshift.		!		* 1		
			1	:		4		
	. On 4/20/16 at	t 4:45 p.m. an interview was	: :e)	·		i		
	— <del>conducted wi</del>	th LPN (licensed practical nurs	***	Facility ID: VA0249	if continuation	sheet Page 56 o		

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	()(0) NALII *	TIPLE CO	NSTRUCTION	(X3) DA	TE SURVEY	
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				1	ì	
AND PLAN OF CORRECTION		IDENTIFICATION TO ME	A. BOILD				С	
		495109	B. WING			<u>'                                    </u>	4/21/2016	
			<del></del>	STREE	ET ADDRESS, CITY, STATE, ZIP	CODE		
NAME OF P	ROVIDER OR SUPPLIER				PEMBERTON RD			ı
	RELS OF UNIVERSI	TY PARK	1		MOND, VA 23233			
THE LAU					PROVIDER'S RIAN OF C	ORRECTION	(X5) COMPLETION	ļ
(X4) ID PREFIX	- · · · · · · · · · · · · · · · ·	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  OF DEFINITION INFORMATION	ID PREF TAG		(EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE	IE APPROPRIATE	DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			DEFICIENCY	)		{
					<del></del>			
		50	F	282				
F 282	Continued From p	page 56	,		1			
	#16, LPN #16 wa	s asked who was caring for						
	$\cdot$ D = $-i$ d and #1 and th	St USA FEM # 10 Legbourger						
		ad for Resident # L. El Nario		i			: 	
Ì		ar or not she was aware or any	<u> </u>					
	special equipmer	it that Resident #1-was to have	:					
	each day. LPN#	16 referred to her computer		:				1
1	system and state	d, "(Resident #1) has an order						}
	for a fleece elboy	v protector to be placed on her	:				:	Ì
	right elbow." LPI	N #16 was asked who was hecking that the fleece elbow						
ļ		I DN #Th residinged digit		i				-
1		SECURING THIS WAS GOING	1	-				
	I allow nor not fr	ia fiaece ellicivi pau vias circoin	ed	İ			1	-
	والمساب المعا	a on Resident #1. Lin 17.19					: :	-
-	:	" I BK # ID Was asked when a	r !	l I				1
1		CHICAG IT DAILIG OIL INGSIDUCIT II II		ļ			; !	
Ì	LONE HAR FORNOR	ided that she had just chooked	:				i -	
	n - Hoof #10 bi	and sugar but Hauli i houses	:	!			3.	- {
	ما فحصد سند دد د	ha tidaca aliiniw Dali was Vi	:					i
}	14 I DNI	THAT SUMPOSED IN IS SUMPOSED IN I	oe :				:	
		. I DN 476 SCCOMUAIISA IIIS					:	
	احما ـ ا	AT WASIMENI # I WILL WAS SIGN'S	iu.	1				
ļ		ik tha minimi i ililii. Illooluuulit ii	•	Ì				ļ
1			ا الر:	!				
	1 DN #4	a chake with Resident # 1 1 1011	į	i			;	Ì
ł	مصافحات المنافق	Satistics   Piv # 10 states and	ŧ				:	
	she would cont	act the physician and get it	D .					
	discontinued si	nce the resident was refusing to	;					
	wearit. LPN#	16 was asked why it was n the TAR that it was on the	1				:	
}		ANG STATON II SHUBBU HULDU	:		!			
	resident. LPN	s on if it is not being placed on	her		P			
	documented a	2 OH II II IO 1101 2 2 11 13 F	1					
	arm."							
ļ	A roulow of the	e facility policy titled					ļ	
	- Batardickinima	ary Care Plail Tevediod, "" Parti	the				:	
	المصاحب الماما	imantatioti / ilic			i 1		1	_
	interdisciplina	ry care plan will; e. Identify the	<u></u>			If continuation	sheet Page 57 c	of 12:

		& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
STATEME AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		С		
	OF PROVIDER OR SUPPLIER	495109		ET ADDRESS, CITY, STATE, ZIP CODE	04/21/2016		
	AURELS OF UNIVERS			PEMBERTON RD HMOND, VA 23233			
(X4) II PREFI TAG	SUMMARY ST X (EACH DEFICIENT X DESCRIPTIONS OR	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OOLD BE COM CELION		
F 2	82 Continued From professional serve each element of opposite provided."	page 57 ices that are responsible for care and frequency of services	F 282		: : : :		
F	At an end of the p.m. ASM (admi facility administration nursing; ASM #3 assurance manamanager; were refindings. No furth prior to the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of the end of th	E CARE/SERVICES FOR BEING  BUT receive and the facility must essary care and services to attair highest practicable physical, who social well-being, in the comprehensive assessmen	•				
	by: Based on obserview, facilia record review, staff failed to pure promote the his 29 residents in	MENT is not met as evidenced ervation, resident interview, staff by document review and the clinic it was determined that the facility rovide care and services to ghest level of well-being for one of the survey sample, Resident #1 ff failed to place a fleece elbow parish right elbow as ordered by the	of				

CTATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG		C	
		495109	B. WING			04/21/2016	
MAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	į	
		TV DAPK			PEMBERTON RD HMOND, VA 23233		
THE LAU	RELS OF UNIVERSI			RICI	EDOVIDER'S PLAN OF CORRECTION	ON (X5)	
(X4) ID PREFIX TAG	ALVOR DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION	
F 309	Continued From p	age 58	F	309	F Tag 309		
	The findings inclu		:				
	The facility staff fa	niled to place a fleece elbow pad			An order was obtained from		
	on Resident #1's	ight elbow as ordered by the		<del>i</del>	the physician to discontinue		
	-physician		·		the order for the fleece elboy	W	
		admitted to the facility on	1		protector due to resident #1'	S	
•	- CMOME with discu	admitted to the facility on noses that included, but were		:	preference.		
	not limited to, CV, stroke), HTN (hyperssure), obesity in the blood streatexpressive aphase	A (cerebral vascular accident - a pertension - high blood y, hyperlipidemia (elevated lipids m), diabetes, sleep apnea and sia (difficulty speaking).			Residents with orders for protective devices have the potential to be affected by the practice.	his :	
	set) was a quarter (assessment reference Resident #1 was BIMs (Brief Interport out of 15. The Macore of 7 indicates severely impaire	erly assessment with an ARD erence date) of 2/10/16. coded on the MDS as having a view for Mental Status) score of IDS manual documents that a tes that the resident's cognition d.	is		The Unit Managers will complete an audit of device currently ordered for reside to ensure the plan of care is being followed and updated needed. The results will be reported to the DON and an	nts s l as	
	a care plan date the following ent	Problems/Conclusions; Skiii:	d		variances will be corrected and continued education provided.		
	decreased ADL incontinence, de Goals: Skin will Goal LT (long te Approaches/Interprotector to R (Interprotector to R) Resident #1 was and times sitting to rost her right	raired skin integrity related to (activities of daily living) ability, ecreased mobility. Measurable remain intact for next 90 days. erm): Reviewed 5/24/16. erventions: Use fleece elbowright) elbow. Start 7/7/15."  s observed on the following date in her wheelchair with a lap traire arm on and there was no fleece at 14,000 at 4,000.	ty :		The DON and ADON will complete in- servicing to licensed staff on providing care and services to promothe highest level of well being to include protective devices.	ote	
	protector on he	r right elbow: 4/19/16 at 4:00			i	nuation sheet Page 59 of 1	

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING _			С
		495109	B. WING			21/2016
NAME OF D	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CO	DE	
				420 PEMBERTON RD		
THE LAU	RELS OF UNIVERSI	TY PARK	R	PROVIDER'S PLAN OF CORF	PECTION	(X5)
(X4) ID PREFIX	CAOU DESIGNENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORN  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE A  DEFICIENCY)	SHO∩FD RF	COMPLETION DATE
TAG	REGULATORI ORI		, ,	: DENOITY		
			,	The Unit Mangers will	audit	
F 309	Continued From p	age 59	F 309	new admissions and ne	ew .	
, 000	p.m.; 4/20/16 at 11	:25 a.m.; 4/20/16 at 4:30 p.m.	;	orders 5x/week for 4 v	veeks to	
		Resident #1's clinical record		ensure devices are ref	lected	
 	Further review of the	physician order sheet)		on the current plan of	care.	
	doormonting in p	art_"active orders (4/1/10		The Unit Managers w	rill — —	
	: Albolach " The fol	llowing order was godumented.	*	conduct rounds 2x/da	V	
	1 "Ctart: 2/1/16 End	6/18//1/ Active Receimed		5x/week to ensure de	vices are	
ļ !	AINAIAG Troatme	int tipecee (SIC) brolector to	}			
	- wast albour a feve	ry) shift while in we (wheelerian	)	appropriately placed	on	
	avony chiff every	shift (sic) (day, eve (evening),		residents with orders.	. Any	
	night). Telephone	order from (name of physician	) !	variances will be con	rected	
t	taken by (name o	of nurse)."	:	and continued educat		
	•		•	provided. The results	of audits	:
	A review of Resid	lent #1's TARs (treatment	. :	provided, the results	a DON	
	- administration re-	cord) for the month of while so is	o o	will be reported to the	E DON.	
	in nort	the tollowing treatment.		1		:
	IIT - atmost avery	shift for Start: 2/1/10 3.37 and	:			
1	: (marning) DC (d	iscontinge) 4/20/10 04.04 Pm	:	Continued complian	ce will be	
	(avaning) Exten	Hed I lirections: Tieecee (Sic)	i.	monitored through the	ne	
	tootor to right	Albow a shift wille in we every				
[	1-16-11 On 4/10/1	R a miree initialed that the heed	:e	facility's quality ass	urance	
	- mantactor Was OF	r Resident #1's fight bloow on u	cay <u>i</u>	program. Additional		
	Lift avaning sh	ift and hight shill. On 4/20/10 a	. !	education and monit	toring will	
ļ	inurse initialed th	at the fleece protector was on	:	be initiated for any i	dentified	
ļ	Resident #1's rig	ght elbow on dayshift.		concerns.		
	·			COMOCHIA,		
	On 4/20/16 at 4:	45 p.m. an interview was	<u>:</u>	G 1-4: Data:		<u> </u>
	conducted with	LPN (licensed practical nurse)		Completion Date:		
	#16. LPN #16 v	vas asked who was caring for		May 26, 2016		
	Resident #1 on	that day. LPN #16 responded	1			i
	that she was ca	ring for Resident #1. LPN #16 ther or not she was aware of an	ıγ ¦			!
	was asked whe	ent that Resident #1 was to hav	e ;	; 4 !		į
	special equipme	#16 referred to her computer		·		
1	each day, LPN	ted, "(Resident #1) has an orde	r :			į :
	system and sta	ow protector to be placed on he	r			
	tor a fleece elbe	PN #16 was asked who was	į .	1		
}	right elbow. Li	checking that the fleece elbow	:	1		
	responsible for	checking that the hoses be. LPN #16 responded that	. !		If continuation s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP COID 2420 PEMBERTON RD  RICHMOND, VA 23233  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 309	
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF UNIVERSITY PARK  (X4) ID PREFIX TAG  STREET ADDRESS, CITY, STATE, ZIP COLUMN 2420 PEMBERTON RD RICHMOND, VA 23233  STREET ADDRESS, CITY, STATE, ZIP COLUMN 2420 PEMBERTON RD RICHMOND, VA 23233  ID PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECT	DE
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF UNIVERSITY PARK  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION STATEMENT OR LSC IDENTIFYING INFORMATION)  TAG  2420 PEMBERTON RD  PROVIDER'S PLAN OF CORRECTIVE ACTION STATEMENT OF DEFICIENCY STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTION STATEMENT OF CORRECTIVE ACTI	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH CORRECTIVE ACTION S  (EACH	(ECHON (NO)
E 200	SHOULD BE COM FELLOW 1
	:
1 E 300   Continued From Dage ov	
everyone was responsible. LPN #16 was asked whether or not the fleece elbow pad was checked	
- # hadov on heing on Resident #1. LPN #10	:
responded, "It is." LPN #16 was asked whether	
1 DN #46 responded that she had just checked	
Desident #1's blood sugar but naght nouced	
the thorogonal the fleece ellow Dau Was U	
I was to be the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the st	
on." At this time LPN #16 accompanied this surveyor to look at Resident #1 who was sitting in	
surveyor to look at Resident #1 who was stated to her wheelchair in the dining room. Resident #1 her wheelchair in the dining room.	
was not wearing the fleece elbow pad to her right	
i - i - ii - ii - DN #16 shoke With Resident #1 thon	
1 +-t-d "/Pacident #1\ does not want it on, it	
about he discontinued." LPN #10 States that	
I have would contact the physician and get it	
discontinued since the resident was reliability to	
1 was it I PN #16 was asked why it was	
degree and the IAR that it was on the	
resident. LPN #16 stated, "it should not be	
documented as on if it is not being placed on her	
arm."	
A review of the facility policy titled	
"Interdisciplinary Care Plan" revealed, in part, the	
fellowing documentation: "Z. The	·
interdisciplinary care plan Will, e. Identity the	
the special convices that are responsible to	!
and clament of care and frequency of services	;
Thore was no documentation in the	
care plan evidence was the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the stat	! ;
the fleece pad on her right elbow.	;
A review of Resident #1's nursing notes did not	Ŧ
and any documentation to evidence that	
Resident #1 refused to wear the fleece pad on	
her right elbow.	•
Hat have a second	us

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER:			C 04/21/2016		
		495109	B, WING	REET ADDRESS, CITY, STATE, ZIP COI		12 1/2010	
	ROVIDER OR SUPPLIER	TV DA⊋V	242	0 PEMBERTON RD			
THE LAU	RELS OF UNIVERSI			CHMOND, VA 23233  PROVIDER'S PLAN OF CORF	RECTION	. (X5)	
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPLETION DATE	
E 000	C. History D	age 61	F 309				
F 309	Continued From p	of Nursing, 6th edition, 2005,					
	Patricia A. Potter a	and Anne Griffin Perry, Mosby, ne physician is responsible for				:	
	directing medical	treatment. Nurses are physician's orders unless they	. :	,			
	helieve the orders	are in error or would harm				:	
	clients."		1			:	
	n m ASM (admir	day meeting on 4/20/16 at 5:50 histrative staff member) #1, the				:	
	facility administra	tor; ASM #2, the director of the regional QA (quality ger) and ASM #4, the regional					
	manager; were manager; manager;	nade aware of the above					
	end of the survey	nation was provided prior to the	F 311	:			
F 311 SS=E	483.25(a)(2) TRE     IMPROVE/MAIN	EATMENT/SERVICES TO TAIN ADLS	; ;				
	A resident is give	en the appropriate treatment and	1	· •			
	<ul> <li>services to main</li> </ul>	tain or improve his or her abilitie graph (a)(1) of this section.	<b>S</b>				
		MENT is not met as evidenced				:	
	document reviev	vation, staff interview, facility w, clinical record review and in the aint investigation, it was	he				
	determined that	the facility staff failed to brative nursing services for one on the survey sample, Resident #2.	of				
	restorative feed	falled to implement Resident #3 ing program per the resident's are on 4/20/16 and 4/21/16.	2's :				
	S-2567(02-99) Previous Vel		32911	-acility ID: VA0249	continuation sh	eet Page 62 of	

CENTERS FOR MEDICA	ARE & MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	- C
AND PLAN OF CORRECTION			04/21/2016
	495109	B. WING STREET ADDRESS, CITY,	
NAME OF PROVIDER OR SUPP	PLIER	2420 PEMBERTON RD	
THE LAURELS OF UNIVE		RICHMOND, VA 2323	33
		DECLIPED OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF TH	DIAN OF CORRECTION (X5)
	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	CPOSS-REFEREN	TIVE ACTION SHOULD BE COMPLETION DATE COMPLETION DATE COMPLETION DATE
		F Tag 311	
	nago 62	F 311	
F 311 Continued Fro	om page 02	Resident #2	is receiving
The findings i	nclude:	restorative	feeding services to
1		include cut	ting up her food.
Resident #2 \	was admitted to the facility on 4/9	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ising her meal
Resident #2's	s diagnoses included but work	intake.	
	. A THOOLIAN I ZI THEITHUIGHING (POI S.	ysis)	
			eceivino
		(5) Residents I	services have the
of the brain r	responsible for language control)		be affected by this
	's most recent MDS (minimum d	ala - ,.	, be allowed by
			and ADON will in-
			rsing staff on
severely im	paired. Section 6 coded residual	ff with	nursing services to
1 1 1114	. transfore messing and persent	=::	e programs and
			on of staff to
resident rec	quired supervision and set up he	p will expectant	e in programs.
eating.	·	parnorpan	, m 1
h to ratio	re progress note signed by ASM	The DON	and ADON will
		O O O	ly for 4 weeks to
			at restorative
			are provided as goals
	the word 'decreased' po (by mou (weight) loss, post CVA	ore swritte	en. The DON will
		110 ·	reekly for 4 weeks
			ve documentation to
			propriateness and
(Illegible v	vord) add to RNP (restorative feeding progra	m daily adjust or	ograms as needed.
		ole to: Any yar	lances will be
		correcte	d and continued
	E = 214 2   LIGOTESISEU SU GIUGU (SY)	-,	n will be provided.
: - !!	12	· · \	•
1 1 1 401 /	an 'x' beside) Pick up utensils, Ho Chew (and) Swallow. Level of		
ltensils_	Chew (and) Swallow. Covered	- W. ID. MAG249	If continuation sheet Page 63 o

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES	L/Y1\ PROMDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG			С
	495109	B, WING			04/	/21/2016
NAME OF PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
THE LAURELS OF UNIVERS				IBERTON RD IND, VA 23233		
(X4) ID SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	^ : ^-	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
		:		And the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s		-
hacida) 6-7 days	beside) Supervision, (a check Frequency: (a check beside)	F 3	mo	ontinued compliance will onitored through the cility's quality assurance		
(minutes) Meet	es Performed per Day: 15 min Goals and Objectives by: April		pr	ogram. Additional		
2016. Tier (a che maintain/prevent interventions: Ap prompts/cues (ar The percent of lic solids consumed (documented as were documente each day from 2/2 Resident #2's co on 3/11/16 documents extensives extensives extensives.	deck beside) Functional- decline in current status. proaches: (an 'x' beside) Verbal and) hand over hand support." quids consumed, percent of the minutes of service 15 minutes) and staff initials and for breakfast and lunch for 16/16 through 4/19/16. Imprehensive care plan reviewer mented, "(Name of Resident #2) y living) related to diagnosis' of	d	be co	ducation and monitoring to initiated for any identificancerns.  Completion Date:  May 26, 2016	will ied	
CVA with right he diseaseRestor orderedUnable PO (by mouth) for tube feeding ordered"	emiparesis and Parkinson's rative nursing program as e to tolerate nutritionally adequation and fluids resulting in need Restorative feeding program	as				
in a wheel chair	:25 a.m., Resident #2 was sitting in the bedroom. The resident	9				
was served a be pancakes, bacc (certified nursing removed all lide up the resident percent. No state the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcent of the parcen	reakfast tray that contained on and oatmeal. The CNA og assistant) serving the meal of from the resident's food and cut's food. The CNA then exited that #2 fed herself and ate 100 aff supervision or support was sident #2 during breakfast.	ıt e				
I had The	8:21 a.m., Resident #2 was sittir e resident was served a breakfas ined a biscuit covered with saus	٥L :				

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

CENTERS FOR MEDICARE & MEDICARD SERVINGELA  (X1) PROVIDER/SUPPLIER/CEIA		& MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDENSUPPLIE VOE	A. BUILDING				c	
AND PLAN OF CORN	_011611					l l	/21/2016	
		495109	B. WING		EET ADDRESS, CITY, STATE, ZI		72 1120 1	
NAME OF PROVIDE	P OR SUPPLIER				EET ADDRESS, CITT, STATE, EI PEMBERTON RD	, 000	\	
					HMOND, VA 23233		ļ	
THE LAURELS	OF UNIVERSI	TY PARK		RIC	DOOM DEDIS DI AN OF	CORRECTION	(X5)	
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREF		THE ACTOR OF THE ACT	TION SHOULD DE	COMPLETION DATE	1
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAC		CROSS-REFERENCED TO DEFICIENCE	I HE APPROFITIALE	)	
TAG R	EGULATORY OR	LGO IDEIVIII						
F 311 Cont	inued From p	page 64	F	311				
	-1 - atmos	J The CNA removed all itos						
	11 40010	2446-501466	£k					-
		food before exiting the room.  observed removing small piece					:	1
			Э				:	
	ک مطاحب د ۱۰۰۰ د	ark ariar in malling the recent						
			ut				-	- }
:an	observation ti	ployee exited the room. At 8:41 a.m	2					
		taran ine inni and donos					:	
· · -	1 1 440 F 64						v V	
1 : .	المحمط بالما	eide to side Hiluloaning 1107	ie į					
	ee	sisistance to Resident #2's exited the room. At 8:45 a.m., to	!					
					! : 		:	
	المنصحب الللا	ant it ene was illibiliou, i vociosi	nt		; ;			
		- was tinichen and the OTM						Ì
rei	moved the tra	ly from the foolit. Resident ne	31C :					
50	percent of th	ne meal.	!				÷ .	ļ
	- 4104146 of 1	1:00 a.m., an interview was					:	
,								
		A THE PERIOR HANGE GODGE GOODS	one		· ·		:	
		ASSOCIATION STRUCTURES						
		s with residents for two to three restorative department works to the standard form care.	with				1	ļ
		** ***********************************	• • • • • • • • • • • • • • • • • • • •				1	
i :	an akakad roc	torative programs molecus pass	ive				:	
	C	s conversions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contractions of the contr						
1 :		A MARIEU JECUTIO BIO SALOT	٥.					
\ C	NA #10 state	ed residents receive restordays	1					
							;	
1	1 (1	Adrams ( INA # 10 Was woner	.0		· }		:	
					<u> </u>		<u> </u>	
-+-	orogram, CN	A #10 stated Resident #2-likes	-		Facility ID: VA0249	If continuation	sheet Page 65 o	of 123

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

CENTERS FOR MEDICAR	LV4V BBOV/IDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	COV	COMPLETED		
STATEMENT OF DEFICIENCIES	IDENTIFICATION NUMBER:	A. BUILD	ING		Ì	c		
AND PLAN OF CORRECTION						/21/2016		
	495109	B. WING				IZ I/ZUIU		
			STREE	T ADDRESS, CITY, STATE, 2	JP CODE			
NAME OF PROVIDER OR SUPPLIE	R		2420	PEMBERTON RD				
				MOND, VA 23233				
THE LAURELS OF UNIVERS	OIT PARA		KION	PROVIDER'S BLANCE	CORRECTION	(X5)		
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			311					
F 311 Continued From	page 65	Г	311					
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right side but t	shown where staff (including							
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		e				<u> </u>		
watching her.	vatching all residents." CNA #10	l		•				
		ng ¦		:	•	:		
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1	L = L = ArAAM	е						
	E = 3 = 4 Adde Sittl IDASE alla acce	1		1				
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	129 VII ( NINK WILL 18910) 601,	As				:		
				•				
		orm :				i ;		
programs. C	eeding programs if she does not			:		:		
						:		
	as asked if Resident #2 was or 15 minutes during breakfast-e							
— — — — monitored for	or 15 minutes during breakdar o	<u>-</u>		Spalling ID: VA0249	If continuation	n sheet Page 66		

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CC	ONSTRUCTION	(X3) DAT	E SURVEY IPLETED
STATEMENT OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			c
		495109	B. WING				/21/2016
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZI PEMBERTON RD	P CODE	<u> </u>
	RELS OF UNIVERSI	TY PARK			HMOND, VA 23233		
		ATEMENT OF DEFICIENCIES	: ID		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	JON SHOULD BE	(X5) COMPLETION
(X4) ID PREFIX TAG	AND ALL DEFINITIONS	Y MUST BE PRECEDED BY FULL (SC IDENTIFYING INFORMATION)	PREFI TAG		CROSS-REFERENCED TO T DEFICIENCE	THE APPROPRIATE	DATE
			_				
F 311	Continued From p	age 66	F	311			
	Jan. CNIA #10 eta	ited the nurse and the CNA					
	were in the room	CNA #10 stated the nuises					-
	and CNAs know t	o cut up Resident #2's food and	_ <u></u>	-			
	to monitor the res	ident.					
1	: On 4/21/16 at 11:	19 a.m., an interview was					:
}	ا طائلید اصطفیات	NA #G (:NA #9 was asked II	į				
	- CNIA - norticinate	in the restorative blograms for	!				
	· · · · · · · · · · · · · · · · · · ·	to etated. We done they (the					
	· · · · · · · · · · · · · · · · · · ·	) have a list. They go around	ļ				
	and do it (provide	restorative programs). We get dressed but don't specifically					
ļ	them (residents) work with them."	Oressed but don't spoomount					
	1		!				<u>.</u>
	On 4/21/16 at 11	:26 a.m., an interview was					:
	المشاهد المصاحب المسا	DNI NICENSEN DIACUCAL HALSSIN	et				*
	: LDN #4 stated st	aff other than the residiative size					•
1	does not typically	y participate in restorative					
	programs unless	one of the restorative					
-	employees is off	•	:				
ļ	On 4/21/16 at 2:	40 p.m., ASM (administrative					
1	staff member) #	1 (the administrator) was made	:				
	aware of the abo	ove concern.	:				
				1			
	The facility police	by titled, "Restorative Nursing"		!			
	documented, "li	ntroduction to the Restorative m: Policy: Restorative care is			<u>:</u>		
	Nursing Program	ocess through which our guests					
	Transitio core an	d services that assist them to	i				:
	- dont and adjus	et to living as independently and			!		•
		ecible Restorative care is a				•	
	I proco	se as dilests alle alueu il i cuilci	ilg I				:
	(a) the experience area to	shveical Amillional Dayonorasio			•		į
	i tal nata	atial Inis nmcess is acinicycu	60 4		į		
1	an atmosphere	that maintains our guests' digni ct, and promotes a lifestyle that i	s		:		ī V
Ì	: 1:1don	t and gett-tittillitie do					i !
	as muchemen	edure: The restorative nursing					heet Page 67 of 1
1	: hasalatatiti i aa			_	ONCOAY ADVING	It continuation s	Heat Lade of of t

		& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY IPLETED	
STATEMENT AND PLAN OF	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:				C	
						/21/2016	
		495109	B. WING	REET ADDRESS, CITY, STATE, ZIP		E HEUTO	1
NAME OF P	ROVIDER OR SUPPLIER	-		20 PEMBERTON RD			
THE LAU	RELS OF UNIVERSI	TY PARK		CHMOND, VA 23233	- MICO	1107-177	
		ATEMENT OF DEFICIENCIES	lD	PROVIDER'S PLAN OF CO	ORRECTION	(X5) COMPLETION	
(X4) ID PREFIX TAG	ACADI DEGICIONO	ATEMENT OF BELLION BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	IE APPROPRIATE	DATE	
	Acting the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon						
   F311	Continued From p	age 67	F 311				
	. programe are Carr	ied out under the direction of					
ļ Ī	the nursing depart	tment, and are provided by		: :			
	Historiand nurses at	nd trained restorative alues.					-
	These programs	employ measurable goals, and luated quarterly (or more often,			······································		
	ea <del>ch guest is eva</del> if need he) Resti	orative programs are provided in	n				Ì
	arouns of four all	ests or less. Nursing					Ì
	managament will	provide supervision for the		•			
	restorative progra	ams and is therefore responsible	<b>3</b>			:	
	for program imple	ementation, program utilization,	•				
	documentation, re	eview of progress, consultation		:			-
	with and evaluate	ons, as needed, by therapists, luation. The nursing staff will b	e				-
	and program eva	tive care through staff					
Ì	development in S	service programs"	1				
ļ							
		ation was presented prior to ex	lt. Þ				
	(1) This informat	ion was obtained from the					
	waheita:	nih.gov/medlineplus/cancer.htm	n!				
	(2) This informat	tion was obtained from the	-				
	wobcite:						Ì
	https://www.nlm	.nih.gov/medlineplus/ency/articl	e/			;	l
	002264.htm						ļ
		the a way obtained from the	:			1	
	(3) This informa	tion was obtained from the			÷		
	website:	nlm.nih.gov/vivisimo/cgi-bin/que	ry-				- 1
	meta?v%3Anro	iect=mediinepius&v%oAsouice	s=				}
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	medlineplus-bu	indle&query=dysphagia				•	
_	_ <u></u>			Sacility ID: VA0249	If continuation sh	neet Page 68 o	f 122

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES & MEDICAID SERVICES

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(Va) MU	TIPLE CO	ONSTRUCTION	(X3) DATE SURV	/EY .D	
CTATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MUL	ing.		1	-	
AND PLAN OF	CORRECTION	IDENTIFICATION NOWBER	A. BUILD	1140		С		
			B WING	ı		04/21/2016		
		495109	D. Wate	CTDE	ET ADDRESS, CITY, STATE, ZIP CODE		ļ	
	ROVIDER OR SUPPLIER				PEMBERTON RD		}	
				2420	HMOND, VA 23233			
THE LAU	RELS OF UNIVERS	ITY PARK		RIG	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
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F 311	Continued Front	on was obtained from the		:			ļ	
}			i	i				
	website:	nih.gov/medlineplus/aphasia.hti	m ¦	<u>i</u> _				
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	<u> </u>							
}	COMPLAINT DE	FICIENCY		F 314				
F 24.4		TMENT/SMCS TO		- 314	F Tag 314			
F 314	PREVENT/HEAL	PRESSURE SORES						
22-1		and of a			Resident #11 has had	•		
	Based on the co	imprehensive assessment of a	ł :		measurements obtained for	all		
ļ				:	applicable pressure areas			
			i	i	identified. The measureme	ents		
}				;	identified. The measureme	1110		
į			·		identified have been			
	they were unave	oidable; and a resident having	and		documented on applicable			
ì			and		facility forms. Resident ha	LS .		
}	door to prot	note realitie, prevent ""			pressure reducing surface	in		
- }	prevent new so	res from developing.			the wheelchair and is offer	red		
1	•				the wheelchan and is ozen			
ļ		MENT is not met as evidence	d		rest periods in the bed.			
\ \	This REQUIRE	MEM IS HOURST AS SAME			Pressure area is resolved			
	by:	ervation, resident interview, sta	ff					
					All residents have the			
					potential to be affected by	this :		
1					, -	-	:	
l					practice.			
					1 . 001		:	
	TURNEI piessu	re safe from developing the survey sample, Resident	#11.		The licensed staff have			
					completed an audit to ens	sure	l	
	: : For Resident :	#11, the facility staff failed to ob	nain		all areas have been identi	itied,		
					appropriate measuremen	ts	1	
1			reekiy !		documented and treatme	nts		
	wound meast	rements and failed to off load	1		Gooding income and a country	n	1	
	pressure.				are in place per physicia	L.	:	
	·		1		orders.			
ļ	The findings	include:	i		]			
			:_		100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 March 100 Ma	Carlo service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service service	5 00	
	<del> </del>				Facility ID: VA0249 If co	ontinuation sheet	Page by C	

	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		1	C
		495109	B. WING				21/2016
NAME OF P	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE PEMBERTON RD	<u>.</u>	
	RELS OF UNIVERSI				MOND, VA 23233		
THE LAU		and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and t		L	PROVIDER'S PLAN OF CORRE	CTION	(X5) COMPLÉTION
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				1			
F 314	Continued From p	age 69	F	314	The DON and ADON	will	•
,	D1-1	admitted to the facility on	ļ	:	complete education to		:
	2/20/46 with diagr	ioses that included but were not			licensed staff on woun	ıd	
	tunited to fracture	ad right hin, respiratory rainare,			identification, staging,		<u></u>
}	aspiration pneum	onia, neurogenic bladder and a			measuring and treatme		
	history of uterine	cancer.			protocols of pressure u		
	The most recent l	MDS (minimum data set)			per company policy.		
	ianamont an a	admission assessificit, with an			per company poncy.		
	: concernent refer	ence date of 4/4/10, coded the		į	The Unit Managers w	ill andit	4
	: Jourt ac coorir	ad a 14 on the Blivio Divio					· :
	· intermitate for man	ital status) indicaling the residen	IL :	:	identified pressure are		
	ia conchia of m	raking daliv codlillive decisions.	i		weekly for 4 weeks to		
	The resident was	s coded as requiring extensive e or more staff members for all of	of !		measuring is complete		1
ļ	assistance of one	laily living except eating in which	1		treatments are followed		
	she required set	un assistance, in Section in -			variances will be corr		:
ļ Ī	Skin Conditions.	the resident was coded as			and continued educati	.on	
	having one Stag	e II pressure uicei and one			provided. The results	of these	
	unstagable - dee	ep tissue injury wound.			audits will be reported		
					DON.		
1	A stage II pressu	are ulcer is described as partial	,		DO11.		
	thickness loss o	f dermis presenting as a shallow	, i				
	open ulcer with	a red-pink wound bed, without ble yellow, tan, gray, green or		:	Cantinged compliana	a will be	
	slough (non-viai	sually moist, can be soft, stringy			Continued compliance		
	ond mucinous it	n texture). May also present as a	an		monitored through th		
	intact or open/ru	uptured blister (1)			facility's quality assu	rance	
			:	:	program. Additional		· ·
	A deep tissue in	njury if a nonblanchable purple o	r	:	education and monito	ring will	
	maroon discolo	ration of intact skill that thay		:	be initiated for any id	entified	i
	Legipoto damad	e to the underlying lissue. (4)	3 :		concerns.		!
	: + + 41 W	rae onsenten on 4/13/10 at 16.01	nt				1
	p.m. and 3:32 p	o.m. in her wheelchair. A reside conducted with Resident #11 on					
1	interview was c	p.m. The resident stated, "My	Ì	i	Completion Date:		:
	. hattam is sare	and has been sole since i got			May 26, 2016		
	here. They did	change the treatment today."		;			: ! :
		as observed on 4/20/16 at 12:4	9 ¦	: 			:
<u> </u>	The resident w	AS ONSELVED OUT TIZELLE CO. TO.			1f	continuation s	heet Page 70

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION  NG	COMPLETED
AND PLAN O	F CORRECTION	100111111111111111111111111111111111111	A. BUILUI		С
		495109	B. WING		04/21/2016
NAME OF F	PROVIDER OR SUPPLIE	ER		STREET ADDRESS, CITY, STATE, ZIP C	CODE
			1	2420 PEMBERTON RD	
THE LAU	IRELS OF UNIVER	SITTEACK		RICHMOND, VA 23233  PROVIDER'S PLAN OF CO	RRECTION (X5)
(X4) ID PREFIX TAG	かんない ちにだいひに	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION	1 SHOULD BE COMPLETION
	1	-	, 	314 ¹	
F 314	Continued From	page /0	ι .	31 <del>4 ;</del>	
ļ !	p.m. sitting in he	er wheelchair. The speech	•		
	therapist was wo	orking with her.	:		
<del> </del>	Review of the "F	Pressure Ulcer Record" dated			
	3/28/16 docume	ented_"Description - Stage II	<del>-</del>		
	cacrum slight or	pened." No measurements were	!	1	:
	dealimented It	did documented no undermining,		:	•
ł	ador or drainac	The color was documented as	i į		:
	"rad" Under the	heading, "Length/Wigth/Depth in	. 1	:	
ļ	cm (centimeters	s) was documented, "UN			
	(unmeasurable)	) "For each weekly		: -	
	measurements	on 4/2/16, 4/8/16 and 4/15/16, a		:	i i
	् "UM" was docu	mented under this column.		•	
ļ		- Decord" dated	•		:
	Review of the "	Pressure Ulcer Record" dated,		:	:
1	3/28/16, docum	nented, "Description - (L) (left)		:	·
	heel, soft, bogg	gy, red, purple." The "Stage" DTI (deep tissue injury). No		! _	:
	documented, i	were documented. It did			
}	measurements	indermining, odor or drainage and	· .		:
	document no a	documented as, "red, purple."		•	
	Under the hear	ding, "Length/Width/Depth in cm	:	•	
	(centimeters) V	was documented, "UM," For each			
	weekly measu	rements on 4/2/16, 4/8/16 and	:		
	4/15/16. a "UN	" was documented under this		:	•
	column.				
			-		:
	Review of the	physician orders dated, 3/28/16,	1		<del>.</del>
	documented '	"Triad Wound Dressing Pasie (3):			:
	tonically every	shift, cleanse sacrum with wo	:	:	
	: (wound cleans	ser), pat dry, apply that cream to	į		
	sacrum. dx (d	iagnosis) preventative wound	if+		
	healing." Skin	Prep (4) to right heel q (every) sh	11.6,		
	dx - DTI."			•	
•		shydician orders dated 4/19/16.	* 1		
	The review of	physician orders dated, 4/19/16, "Greer's Goo (5); topically three	i	:	
	documented,	pply Greer's goo to sacrum area q			
	nhitt offootive	4/18/16 - wound healing."			

	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY PLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING			c
		495109	B. WING		04/2	21/2016
	PROVIDER OR SUPPLIER	TY PARK	242	REET ADDRESS, CITY, STATE, ZIP CODE 20 PEMBERTON RD CHMOND, VA 23233		
ITE LAC			ID	PROVIDER'S PLAN OF CORREC	TION	(X5) COMPLETION
(X4) ID PREFIX TAG	ノニ へつい ロロロじじにんかつ	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	IULD BE	DATE
	: 					
F 314	Continued From p	age 71	F 314			
	Review of the Mar	ch and April TAR (treatment ord) revealed the treatment was				
	documented as or	dered.				
	sacral wound and	as made of Resident #11's heel wound on 4/20/16 at 1:30 dent in bed with LPN (licensed 11 and LPN #12. The sacrum				:
	revealed three op measured by the	en areas. The areas were facility staff as: 1 x .5 cm, .5 x .5 cm. When asked why the areas	5			
	observation of the had so many ope	ed prior to today (the day of e wound) LPN #11 stated, "She in areas so we didn't measure 1 was asked how staff could tel				
	if the wounds we were being obtain	re healing if no measurements ned. LPN #11 stated, "Well, if ny areas, how am I to measure				
	them?" When as wound, LPN #11	ked about measuring the need stated, "I can only go by what I on Fridays, I didn't do the initial	:			
	assessment." At	fter the observation was #12 asked Resident #11 if she ff her bottom, and she stated,	·	: : :		: :
	"Yes, that would was asked if she	be great." when the resident e normally takes a rest every day	У			1
	in bed, she state	ea, INU.	i			
	a.m. In her whee she had been of afternoons prior Resident #11 st	as observed on 4/21/16 at 8:16 elchair. The resident was asked ffered to go back to bed in the to 4/20/16 to get off her bottom ated, "No, the first time was /16). It's actually the first time	ì			
	they ever sugge bottom."	ested I go to bed to get off my	-			

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF I	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG		C C CAUCALODAG
ı		495109	B. WING	STREET ADDRESS, CIT	Y, STATE, ZIP CODE	04/21/2016
	VIDER OR SUPPLIE			2420 PEMBERTON RI RICHMOND, VA 23	כ	
THE LAURE	LS OF UNIVERS	SILY PARK		: DROVIDED	S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG	X (EACH CORR	ECTIVE ACTION SHOULD ENCED TO THE APPROPE DEFICIENCY)	DE STEE
R	atad 3/20/16 at	page 72 ursing Admission Assessment" t 1:16 a.m. did not reveal any on the pressure ulcers.	F .	314		
V	he nurse's note vere reviewed.	es dated 3/28/16 through 4/19/16 On 3/28/16 at 3:48 p.m. it was suest has 2 skin issues noted." ther documentation regarding the				
	4/12/16, docum skin integrity rel "Approaches" dweekly and documently and documented, "I skin integrity r/" mobility, inconforcumented in chair." The corumpaired skin impaired skin impaired skin	omprehensive care plan dated, ented, "Problems: Actual impaire lated to Sacral Wound." The locumented in part, "Measure are cument it's characteristics in the de assistance to reposition as needed." The care plan Problem: Potential for impaired it (related to) decline in function a tinent episodes, current skind diagnosis." The "Approaches" a part, "Limit the time sitting in morehensive care plan dated, mented in part, "Problem: Actual integrity related to heel wound." hes" documented in part, "Measund document its characteristics."	and			
	The "Braden Sore Risk" da scoring a "16" developing pr	Scale - For Predicting Pressure ted, 3/28/16, coded the resident indicating that she was at risk foressure ulcers.  Was conducted with administrative (ASM) #2, the director of nursing the same with a pressure unit in the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same with a pressure to the same	as or /e			
	ulcer, describ	ped as a Stage II should be SM #2 stated, "If it's measureable on where it's located anatomic	le. It		If contin	nuation sheet Page 73 of 12

	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY APLETED
AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:			0.4	C /21/2016
		495109	B. WING	TREET ADDRESS, CITY, STATE, ZIF		12112010
NAME OF P	PROVIDER OR SUPPLIER	-	1	420 PEMBERTON RD		
THE LAU	RELS OF UNIVERSI	TY PARK		RICHMOND, VA 23233		
	OLD ALADY CT	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT)	ORRECTION ON SHOULD BE	(X5) COMPLETION
(X4) ID PREFIX TAG	COLOUR DEFICIENC	CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TO	HE APPROPRIATE	DATE
				[ : :		
F 314	Continued From p	age 73	F 314	, V f )		
	Would have to se	e it to tell you that answer."				
	: : An interview was	conducted with ASM #3, the	:			
	· ··· ·· ional OA (auai	ity assurance) manager, on				
	4700146 OF 2:07 N	m "When asked II a Stage II				•
	il managura area shi	auld he measured. Aoivi #2	!	:		•
 	· "Voc " \//h	ian askad it a deeb iissus iiijury				•
l 	should be measu	red, ASM #3 stated, "I would."				
		"Dranguro I lloer Record"		:		
	The facility policy	r, "Pressure Ulcer Record" olicy: All pressure ulcers are to b	e.			
	documented, re	he pressure ulcer record weekly	y. i	•		
	documented on a	ecord the date and site when firs	st (	•		
į	Figure Pools	ment in the description the		•		
	Incotion and ann	earance of the pressure dicer-	5. i			
ļ	Degument the W	ound stage. b. Measure the				
		eters and record the rengin,				
1	deb and denth	( 10 The comments should	1			
1	address nain di	ainage amount, peri wound are	a			
Ì	and progress of	response to treatment 14.				•
	: Confinue to mes	asure and document the would				
	-very cover dal	/s " The facility policy, in essur	E			
	Ulcer Identificati	ion and Treatment Protocols -				
]	Deep Tissue Inj	ury: Purple or maroon localized	:			
	area of discolor	ed, intact skin or blood-filled				
	blister due to da	amage of underlying soft tissue and/or shear. The area may be	1			
1	anneaded by tie	erre that is bainful, IIIIII, mushy,	-			
ļ	Langua Marmar	or cooler as compared to adjac	GIIC			
ļ	7 Ev	aluation wound and document.	i			:
}	Degument loca	fion stage, length and widin (or	!!),			: <u>1</u>
	solor treatmen	fand progress at least weekly c	and	į		1
	if the condition	of the wound changes."		!		:
	<u>.</u>		nt			
	Treatment of P	ressure Ulcers, U.S. Departmen	TH.			1
-	af Waalth and t	Juman Services, Fublication				:
	Number 15 de	ocuments, in part on page o.	1	:		:
	114	Acceptaing the Pressure Order	to ·	<u></u> .		
	— Pressure ulcer	s should be uniformly described	* . <del>*</del>	10.111.00.10	If continuation s	heet Page 74 of

CENTER	S FOR MEDICARE	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
STATEMENT ( AND PLAN OF	OF DEFICIENCIES - CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		ì	C	
	ROVIDER OR SUPPLIER		2420	ET ADDRESS, CITY, STATE, ZIP (		21/2016	
THE LAU	RELS OF UNIVERS			HMOND, VA 23233  PROVIDER'S PLAN OF CO	ORRECTION	(X5) COMPLETION	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID : PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	DATE	-
			F 314			i	
F 314	etallophe arrana	ications among staff and to monitoring of the progress	1 314				
	oration of th	To monitor progress or the lesion, the examiner must	: -				-
	accurately meast the ulcer and des undermining, neo presences or abs epithelization."	re length, which and depth of cribe sinus tracts, tunneling, crotic tissue, exudate and the sence of granulation tissue and					
	Health and Hum Guidelines, Publ part on page 26: Support Surface developing a pre uninterrupted sit individual should points under pre put back to bed goals. Rational the etiology of prolonged, uninter tissue results.	in Adults, U.S. Department of an Services, Clinical Practice ication Number 3, documents, is "Mechanical Loading and s: 8. Any individual at risk for essure ulcer should avoid ting in a chair or wheelchair. The be repositioned, shifting the essure at least every hour or be if consistent with overall patient e: The findings of researchers of the researchers indicated that terrupted mechanical loading of the insue."	ne [:]				
		tor, ASM #1, ASM #2, the direct					
	assurance) ma manager, were concern on 4/2	nager and ASM #4, the regional made aware of the above 0/16 at 6:18 p.m.				: :	
	No further info	rmation was provided prior to ex	cit.		•	} -	
	(1) This inform for Medicare & Care Facility F User's Manua	ation was obtained from: Cente Medicaid Services; Long-Term Resident Assessment Instrumen ; Version 3.0 July 2010, pages	rs !				
	— <del>(2)</del> This inforn	nation was obtained from the		Enablish ID: VA0249	If continuation s	heet Page 75 c	ıf 12

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	(VOLMUIT		CONSTRUCTION	(X3) DATE	SURVEY	
STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	PLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION, TOMBETT	A. BUILDI				C	
		15.54.00	B, WING			04/	21/2016	
		495109	1 2: ******	STRI	EET ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIER				0 PEMBERTON RD			
!					HMOND, VA 23233			
THE LA	URELS OF UNIVERSI	II FAIN			PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
A(4) (D	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREFI		ACTION SHOUL	LD RF	COMPLÉTION DATE	
(X4) ID PREFIX	THE PROPERTY OF THE NAME OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRO DEFICIENCY)	iPRiA1 E		
TAG	REGULATORY OR	Lac IDEIVIN (INC. II)			DEFORM			
	: 			:				
	. a company	ogo 75	F:	314			l	
F 314		age 10						
	website:	m.nih.gov/core/lw/2.0/html/tilesl	٦Ì					l
	http://www.ncbi.nii	pmc_inline.html?title=Click%20	1	i				l
	op_pmc/tiles1109_	to%20zoom&p=PMC3&id=269	7					
		-ina						
	(a) Zina avida-hag	sed hydrophilic paste ausorus						
	doroto lovoje c	of wound extigates. Autolytic		:				
	tion poftone and	d innsens necrotic tissue wille		1				
Ì	sintaining a MO	ist wound environment. This		i				1
	information was o	obtained from the website:	3	1				1
		dsource.com/product/triad-hydre						1
	philic-wound-dres	a liquid film-forming dressing the	at				:	1
	forms a protective	e tilm to help reduce modern	:	1	:			
	during removal 0	t tabes and tiltus. This			<u>.</u>		:	
	information was	obtained from the website:						
	allearomed	lical.com.					;	
	Exercise Cools	o a mixture of IOVStatill.	n '					
	hydrocortisone, a	and zinc oxide). This illioithado	[1]					
	- l-t-inad fra	m the Wensite:	1					
	http://www.ncbi.i	nlm.nlh.gov/pmc/articles/PMC4	,					
Į	6799/	TREATMENT/SERVICES -		F 322				
F3	322   483.25(g)(2) NG	TREATMENT/SERVICES -			:			ļ
SS	S=D RESTORE EAT							}
	Based on the CC	omprehensive assessment of a						
	resident, the fac	cility must ensure that						
	:				:			$\dashv$
	(1) A resident w	ho has been able to eat enough	n trio				•	1
	along or with 25	seigtance is not led by hasy you	iu ic					
Ì	i tule - walaan tha	regident 's clinical conduitor	1					- [
1	demonstrates t	hat use of a naso gastric tube v	,		!			
	unavoidable; ar	ıu	:					
	(a) A modidant w	vho is fed by a naso-gastric or	Ì		1		1	
ļ	trantamy til	he receives the appropriate	:					
ļ	the street and i	CANACAS IN DIEVELL GODILATION					1	
}	pneumonia. dia	arrhea, vomiting, dehydration,						
1	Pr.,====================================					tinuation of	neet Page 76 of	122

#### FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A, BUILDING _ AND PLAN OF CORRECTION 04/21/2016 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 495109 NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD RICHMOND, VA 23233 THE LAURELS OF UNIVERSITY PARK PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG F 322 F 322 Continued From page 76 metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating F Tag 322 This REQUIREMENT is not met as evidenced Resident #14 received orders from physician services Based on observation, staff interview, facility by: during survey for tube feeding document review and clinical record review, it to be at 50mls/hour. was determined that the facility staff failed to administer a tube feeding at the rate ordered by the physician for one of 29 residents in the survey Residents receiving tube sample, Resident #14. feedings have the potential to be affected by this practice. The facility staff failed to administer Resident #14's tube feeding at the physician-ordered rate The DON and ADON will inof 40 mls (milliliters) per hour. service licensed staff on The findings include: guidelines for medication orders to include verbal Resident #14 was admitted to the facility on 4/7/16 with diagnoses including, but not limited to: orders. history of a stroke, chronic obstructive pulmonary disease, Bipolar disorder, and heart disease. The Unit Managers will complete an audit of all The resident had not been in the facility long residents with orders for tube enough for an MDS (minimum data set) assessment to be submitted. A review of his feeding to ensure they are admission nursing assessment dated 4/8/16 receiving prescribed amount revealed that the resident had difficulties and rate. understanding and being understood by others. The assessment revealed that Resident #14 had a PEG (Percutaneous endoscopic gastrostomy tube*) tube in place.

PRINTED: 05/05/2016

	NT OF DEFICIENCIES	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAT	N OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILD!	NG		С		
		495109	B. WING			04/21/20	)16	
				STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
	OF PROVIDER OR SUPPLIER				PEMBERTON RD			
THE L	AURELS OF UNIVERSI	TY PARK		RIC	HMOND, VA 23233	TION	(X5)	
(X4) II PREFI TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X6) APLETION DATE	
		* ·	·	322	The Unit Managers will			
F 3	22 Continued From p	age 77	r.	322	continue to audit all new	7		
	On 4/19/16 at 2:30	p.m., Resident #14 was			orders and admissions	:		
	abanyad king in l	nis had with the head of bed	1					
	elevated. A tube t	feeding was being administered			5x/week for 4 weeks to			
1	through the PEG	tube at the rate of 50 mls/hour.	:	:	accuracy. Any variances			
<u> </u>	Observations on	4/20/16 at 8:10 a.m. and 11:40 resident in a similar position in	1	- :	be corrected and continu			
	a.m. revealed the	feeding at the same rate of 50			education provided. The	<b>;</b>		
	mls/hour.	resulting at any summer	1		results of these audits w	ill be		
	mis/nouc.		:		reported to the DON.			
1	A review of Resid	lent #14's clinical record	i		1			
	rovealed the follo	wing provider's order dated and	!	1		_:11 Lo		
	signed by the DUI	se practitioner on 4/10/30.	:	:	Continued compliance v	will be		
ļ	"Doctor tune fee	ding iname of tube recurry		•	monitored through the			
1	product] at 40 mi	/h and 300 mi water itush q + ii			facility's quality assuran	nce		
1	every four hours	3)."			program. Additional			
		Contract April 2046 MAR			education and monitoring	ng will		
Ì	A review of the re	esident's April 2016 MAR Inistration record) revealed no			be initiated for any ider	ntified		
Ì	(medication adm	order. The most recent entry on	-					
	evidence of this	ented: "Enteral feeding			concerns.	•		
	the MAR docum	4 hours at 50 mi/hour."						
					Completion Date:			
	On 4/10/16 at 11	:40 a.m., LPN (licensed practical	al		May 26, 2016			
		ananied inis silivevui lu ilie	i		: :	:		
	-i-lthe bodei	de When asked to verny the re-	ie					
	of the tube feed	ing he stated: "It's fullilling at or	J			•		
-	bour" \//ha	n asked it he was awaie of the	!		1			
+	rata currently or	dered he stated: "It's ou. VVIII	P1 }			· · · · · · · · · · · · · · · · · · ·		
	LDNL#2 chacker	d Resident #148 Chan and saw						
ļ	the above-refer	enced order, he stated: "Uh oh. e order had changed. Someone	.			÷		
	didn't realize the	order off." He stated that he wou	ıld			i		
1	II tha phycicis	an When asked the process for				:	•	
	-kaakina a tube	s teeding rate. He stated. I go b	y !			1	:	
1	. ILdara that	are in the computer. The states	4			:		
ļ	Line woner order	in the chaff for 40 IIIIs/IIIuui Bay			į	!		
	not been transe	ribed to the computer, so he are			į	•		
	not know that t	he rate had changed from 50	į			:		
ļ	mls/hour to 40	mls/hour.				antinuation sheet Pa	70 70	

		& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3)	DATE SURVEY
STATEMENT AND PLAN OI	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		NG	_	С
		495109	B. WING			04/21/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 2420 PEMBERTON RD		
THE LAU	IRELS OF UNIVERSI			RICHMOND, VA 2323	PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(CASU DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORREC) CROSS-REFEREN	TIVE ACTION SHOULD BE ICED TO THE APPROPRIAT EFICIENCY)	COMPLETION DATE
F 322	Continued From p	age 78	F:	322		
	4/20/16 revealed,	ent #14's care plan dated in part, the following: "Tube	-			
	feeding as ordere	d."	:			
	staff member) #1 director of nursing assurance manag manager, were in  A review of the fa Enteral Feeding I Administration re following the provadministration.  No further inform  *PEG tube - "Per gastrostomy tube for the purpose on utrition." This is website www.nlr In Fundamentals Patricia A. Potte	s of Nursing, 6th edition, 2005, r and Anne Griffin Perry, Mosby The physician is responsible fo	· · · · · · · · · · · · · · · · · · ·			
F 33	obligated to folk believe the order clients." 28 483.25(k) TREA NEEDS	al treatment. Nurses are ow physician's orders unless the ors are in error or would harm ATMENT/CARE FOR SPECIAL		F 328		; ; ;
	The facility must proper treatment special services Injections;	ot ensure that residents receive nt and care for the following s:				
				= .0015.VA0940	If continuati	ion sheet Page 79 of 1

CENTERS FOR ME	DICARE & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
STATEMENT OF DEFICIENC AND PLAN OF CORRECTIO				c
AND PLAN OF GOTTIES		B WING		04/21/2016
	495109	STI	REET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR	SUPPLIER		20 PEMBERTON RD	
THE LAURELS OF U	NIVERSITY PARK		CHMOND, VA 23233	CVE)
	MMARY STATEMENT OF DEFICIENCIES	ID .	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	JULU DE L'ESTE I
	MMARY STATEMENT OF DEFICEDED BY FULL DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE DATE
		ì	F Tag 328	
	1 Frame 2000 70	F 328	1 1 ag 320	
F 328 Continued	d From base 19		Resident #11 has their	r hand
Parentera	al and enteral fluids; y, ureterostomy, or ileostomy care;	:	held nebulizer stored	in a bag.
Colosion	tomy_care;	:	when not in use per fe	acility
Tracheal	suctioning;		I .	
Respirato	ory care;		policy.	
Foot care	e; and		D 'I who reacts in a r	ehulizer
Prosthes	es.		Residents receiving r	votential
			treatments have the p	practice
This RF	QUIREMENT is not met as evidenc	ed	to be affected by this	practice.
1		:	TT 10 7 f	-211
ا شا	on observation, staff interview, facilit	y it	The Unit Managers v	WIII
	-t raviaw and clinical record revers	18	complete rounds 5x/	Week 101
	ermined that the facility staff failed to spiratory equipment in a sanitary ma	41 11 101	4 weeks to ensure pr	oper
store re	of 29 residents in the survey sample	, .	storage of nebulizer	
Resider	nt #11.		equipment. Any vari	iances Will
		: not	be corrected and cor	itinued
Resider	nt #11's nebulizer treatment equipme	nitary :	education provided.	The
was ob	served not covered or stored in a sa	intery	results of the audits	will be
manner	to prevent infection.	:	reported to the DON	Į. į
The fire	dings include:	į		
			Continued complian	ce will be
Reside	nt #11 was admitted to the facility or	nore not	monitored through the	he
-100144	Suite diagraphs that included but w	are nor :	facility's quality ass	urance
	to: fractured right hip, respiratory fa ion pneumonia, neurogenic bladder		program. Additiona	
aspirat	of uterine cancer.		education and moni	toring will
;			be initiated for any	identified
The m	ost recent MDS (minimum data set)	ith an		
· ·	L an admireion assessinous v	1161: CX1 :	concerns.	
1	rotoronce dale ul 4/4/10, 204	Ou	a 1-4: Data:	
	nt as scoring a 14 on the BIMS (brie ew for mental status) indicating the		Completion Date:	ž.
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	May 26, 2016	 
			!	
her as	ance of one of more stan more ating in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a parting in a par	n which	If .	continuation sheet Page 80 of

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

OF MIE		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	LIPLE C	10149 LV0C 1:014	C	OWELFLED	-
STATEMENT (	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			С	
AND PLAN OF	CORRECTION						-	Ì
		495109	B. WING				4/21/2016	-
			1	STF	REET ADDRESS, CITY, STATE, ZIP (	CODE		}
NAME OF P	ROVIDER OR SUPPLIE	:R		242	0 PEMBERTON RD			
	RELS OF UNIVERS	SITY PARK		RIC	CHMOND, VA 23233			_
THE LAU			· · · · · · · · · · · · · · · · · · ·		PROVIDER'S PLAN OF CO	ORRECTION	(X5)	.
	SUMMARY S	STATEMENT OF DEFICIENCIES	iD PREF	ΙΧ	CAOLLOODDECTIVE ACTIO	N SHOULU DE	COMPLETION DATE	N
(X4) ID   PREFIX			TAC		CROSS-REFERENCED TO THI DEFICIENCY)	F WALKOLVIVIE		}
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)						
			İ	1			•	}
ļ			F	328				
F 328	Continued From	page 80	•					
	she required set	up assistance.		:				
			+	:				
	On 4/19/16 at 12	2:03 p.m. and 3:32 p.m., Residen	it :	<u>'</u>				
	i ina is la idimorti	treatment annaigus was	1					
	1	of the aresset. Not stored in a						l
l	i i i i i i i i i i i i i i i i i i i	mack was instructing on the	i ·					l
		SKINDAR GRUNNING WAS AGON	d :					
1			-		<u>:</u>			Ì
}	1:30 p.m. Durin	ig each observation the nebulizer	· '					ļ
1	equipment was	not covered or stored in a plastic	•		1			ł
ļ	bag.							Ì
1		orders dated 3/28/16, documente	d,					}
		SALABAR TA 9 (1855 U) 11100100000						
ļ			:					
į								}
1	صنطاط والمسادين		:					1
ļ	(milliliters) Sus	sp (suspension); one half MG	:		1			ļ
1	nebulizer twice	e daily."	:					
ļ			1					
1	A review of Re	esident #11's MAR (medication						1
	· 1 11	racard for Wai Cit and April 40	)		İ			ļ
ŀ	revealed docu	mentation the medication was	į				•	Ì
	administered	as ordered.			1			Ì
			i		!		:	
1	. The compreh	ensive care plan dated, 4/12/16,	arv/				•	ľ
	:	"Drahlams, Bullelilla 101 1008" an	nd i		i i			
}	attionation r/t :	(related to) filstory or brondings a					•	
İ	episodes of s	hortness of breath." The	r !				1	
ļ	"Approaches"	" documented in part, "Administe	S.				1	
1	medications	& treatments per physician orders	Ì				<u>†</u> 	
	Monitor for e	ffectiveness, side effects and stions of medications and treatments	ents				:	
	adverse read	onormal findings to physician."	1					
-			į.				í !	
	,	room for a wound observation w	ith				\$ 1	
		!	·					
					İ			
	7:30 p.m. Lr	nt #11's nebulizer mask and tubin	<u>g,                                     </u>				on sheet Page 8	31 of 12
+	With resider	15,011,0	1102044		Facility ID: VA0249	if continuation	ni pricer Lade r	., J. 1A

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  ING	(X3) DATE SURVEY COMPLETED C		
		495109	B. WING			4/21/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 2420 PEMBERTON RD RICHMOND, VA 23233	ZIP CODE		
(X4) ID PREFIX TAG	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 328	Continued From p	It's not in a bag."	F	328			
	An interview was	conducted with administrative		· 			
	start member (AS	M) #2, the director of nursing, 3 p.m. When asked where a					—
	nehulizer treatme	nt apparatus is stored, ASM #2		:		l	
	stated "At the res	sident's bedside." When asked		; ;			
	how the apparatu	s is stored, "Bagged and dated."	1	ı			
	Regional QA (qua 4/20/16 at 2:04 p treatment appara "Stored in a bag,	conducted with ASM #3, the ality assurance Manager) on .m. When asked how a nebulize tus is stored, ASM #3 stated, labeled and dated."	; r :				
	The facility policy documented, "13 shake dry and pl	r, "Aerosol Treatments" . Disassemble hand held unit, ace in bag."				:	1
	Patricia A. Potter Inc; Page 648. " of Health Care-A Respiratory Trac therapy equipme	or. ASM #2, ASM #3 and ASM #4	1,			i	
	the regional mar	nager, were made aware of the					
	No further inform	n 4/20/16 at 6:18 p.m. nation was provided prior to exit. tion was obtained from the					
F 35	website: https://www.nlm ds/a699056.htm 6 483.30(e) POST	.nih.gov/medlineplus/druginfo/m il FED NURSE STAFFING		F 356			
				المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة الم			

CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			С	
		495109	B. WING				4/21/2016	3
NAME OF F	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE,	ZIP CODE		
THE LAU	RELS OF UNIVERSI	TY PARK			PEMBERTON RD IMOND, VA 23233	AND MANY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PA		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE	TION
				-			:	
F 356	Continued From p	age 82		356				
	The facility must p a daily basis:	ost the following information on	:	!			•	
	o Facility name.		<del> </del>	<u>:</u>				
	o The current date	e. Ir and the actual hours worked	<u> </u>					
	by the following ca unlicensed nursing	ategories of licensed and generally generally staff directly responsible for	:				•	
	resident care per - Registered r	iurses.		:				ļ
	<ul> <li>Licensed pra vocational nurses</li> <li>Certified nur</li> </ul>	actical nurses or licensed (as defined under State law). se aides.	an ag	-				
	o Resident censu	S.	:					
	specified above of of each shift. Da	place readily accessible to	:	·				
	make nurse staff	upon oral or written request, ing data available to the public ost not to exceed the community	,					
	The facility must	maintain the posted daily nurse	. !					
	staffing data for	a minimum of 18 months, or as e law, whichever is greater.	:	•				
				:			1	
		MENT is not met as evidenced		-			: :	
	document revie	rvation, staff interview, and faciling, the facility staff failed to ensure.	:e	: : : : : : : : : : : : : : : : : : : :				
	accurate nurse of the survey pr	staffing was posted for two days	<b>!</b>	:			:	
-	The findings inc	lude:				If continuation	sheet Page	83 of 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	c
					04/21/2016
		495109	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	U-4/2-112010
NAME OF P	ROVIDER OR SUPPLIER				
			}	2420 PEMBERTON RD	ļ
THE LAU	RELS OF UNIVERS	IIY PARK		RICHMOND, VA 23233	TION) (YE)
(X4) ID PREFIX TAG	(EVOLLDERICIEM)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE COMPLETION
F 356	Continued From p	page 83	F3	F Tag 356	
	0 44040 0 0	anm 1:30 nm (with two		The facility has the sta	ffing
	On 4/19/16 at 3:3	0 p.m., 4:30 p.m. (with two at 5:00 p.m., observations of the		posted daily and actua	l hours
	"Report of Nursin	a Staff Directly Responsible for	:	are updated each shift.	, per
<u> </u>	—Danidant Cate" Di	asted on the bulletin board to —		regulations.	
	the left of the reco	eptionist's desk in the lobby were imented on the form was the S WORKED" for "7 a.m 3:30 no documentation for the next	9	Residents and visitors affected by this practi	ce.
	On 4/20/16 at 8:2	20 a.m. an observation was "Report of Nursing Staff Directly	/	The DON and ADON trained the staffing	:
	Responsible for	Resident Care form. Almough e form documented "ACTUAL ED" all three shifts were already	j	coordinator on new to post projected and ac hours each shift daily 11 shift and 11-7 shi	tual v. The 3- ft will be
	interview ASM (a the director of no office, but ASM a	20 a.m., an attempt was made to administrative staff member) # 2, urses. ASM #2 was not in her # 3 the regional Quality ager directed this surveyor to	; ; ;	educated to update st posting each shift.  The DON will audit staffing sheet 5x/we	the
	ASM # 1, the ad	Iministrator. These observations ASM # 1 and a request was mad staff responsible for filling out the ty policy was requested at this		weeks to ensure according to the DON will report res	uracy. The ults to the s will be
	oSM (other state coordinator, the was reviewed. work on 4/19/10 that the Director assistant direct Nursing Staff Decre) out ASI	view on 4/20/16 at 8:40 a.m. with ff member) # 9, the staffing staffing or 4/19/16 and 4/20/16 OSM # 9 stated that she did not 8 so she did not know but stated or of Nurses (ASM # 2) or the cor of nurses fills it (Report of Directly Responsible for Resident M # 2 was in the room at that time hought   filled it out." Observation	e	corrected and conting education provided.	nued

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

OLIVIEIT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		NSTRUCTION	COV	PLETED
AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			c l
							/21/2016
		495109	B. WING		ET ADDRESS, CITY, STATE, ZIP CODE	1 0-4	112010
NAME OF F	PROVIDER OR SUPPLIE	R	ļ				
					PEMBERTON RD		
THE LAU	RELS OF UNIVERS	SITY PARK		RICH	IMOND, VA 23233	ION	(X5)
(X4) ID PREFIX	ACADIL DEDICIEN	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TD RE	COMPLETION DATE
TAG	REGULATOR					and the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contr	
			:	:	1 maliance Wi	II he	
F 256	Continued From	nage 84	F	356	Continued compliance wi	11 00	
# 330	Collinaed Light	shared with ASM # 2 and ASM #	:		monitored through the	. 0	
	0) 4/19/16 Were :	g more. OSM # 9 was			facility's quality assurance	e	:
	2 offered Homans	it her process of filling out the		i	magram Additional		
	-taffing raport (	CAM # 9 stated, she gets the	1	· · · · · · · · · · · · · · · · · · ·	adjugation and monitoring	g will	
	Decident census	sand but that on (the torial) were		_ <del></del> _	be initiated for any identi	fied	
1	I - b - looks at the	echedule and this out the rest of	1	i			•
	the form for the	whole day. OSM # 9 stated, the		·	concerns.		
	most day when s	the comes in, she checks what					· •
l.	-1-ff -ama to 18/6	and then thes back and	_	Ì	Completion Date:		
		ing in red ink. When asked when	3		May 26, 2016		
	those forms are	nosted. USIVI # 9 Stated they are	-	į.	•		
Ţ	not posted they	are all kept in my (Ook # 99)	!				:
	book with the so	chedules.	i	į	•		1
	•	4/20/16 of	·	ļ			1
ļ	During the end	of day interview on 4/20/16 at		-			į
	·	RAND M ASIVITALINING COLVE	<b>a</b> :	ļ			
1	staff member)	#1, the administrator, ASM #2, the	, ,	İ			†
	director of nurs	ing, ASM # 3, the regional Quality		İ			
	Assurance Mar	nager, and ASM # 4, the Regional		į			
	Manager, were	informed of this concern.	:				
	m	facility policy: "STAFFING -					
	Keview of rife i	OSTING OF" "Policy: The facility		!			
	taily food daily f	or each shitt the number of		-			
	Hennood and H	nlicensed hursing stall directly		ļ			
1	zaanansihle foi	r quest care in the facility. This		1			
	information Wil	i he prominently displayed in a					
_	the area bo	S & X 12 inches, Dillieu in a	.	1			
	Hantlarge	annumb to be easily read, in usion	d				]
	Lateran office mi	uet include the actual Hullipel of	i	!			ļ
	Hooppood and I	inlicensed staff directly responsibility	ie	!			:
1	Comblee core of	collects for that particular day on					:
	lanch chift lie	ranged and Unlicensed Hursing of	ап				i
	includes: regis	stered nurses, licensed practical	:				į
	nurses, and n	urse aides."	i	F 371	1		:
F 3	74 402 25(i) EOC	ND PROCURE.	1	r 3/ i			:
	=F STORE/PRE	PARE/SERVE - SANITARY	ļ		1		
33			•		1		
SS	S=F STURE/PRE	-AILIOLITE CONTRACTOR	:				

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NI IMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	С
		495109	B. WING		04/21/2016
NAME OF D	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
				2420 PEMBERTON RD	
THE LAU	RELS OF UNIVERS	HY PARK		RICHMOND, VA 23233  PROVIDER'S PLAN OF CO	ORRECTION (X5)
(X4) ID PREFIX TAG	CALOU DESIGNATIONS	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		IE APPROPRIATE DATE
F 074	Continued From p	nade 85	: F3	371	
r 3/1	The facility must -			! !	
	: (4) P food f	rom sources approved or actory by Federal, State or local	į	4	
	outhorities, and			F Tag 371	
	(2) Store, prepare	e <del>, distribute and serve food</del> ——			
	under sanitary co	nditions		The frozen beef pa	atties were
]	•			discarded during t	he survey,
]	;			as an extra precau	tion. The
	· •			plastic bin of suga	ar was
				emptied, cleaned	and re-filled.
	This REQUIREM	IENT is not met as evidenced	i i		
	by:	vation, staff interview, and facilit	V	Residents have th	ne potential to
	document review	v it was determined that the	•	be affected by thi	is practice.
	facility staff failed	d to store food in a sanitary			
	manner.			The Dietary Man	nager, or
	:	i di and a hay	,	designee will in	service all
1	A plastic bin of s	sugar was left opened, and a box	`	dietary staff on s	toring,
1	of frozen beet pa	atties that had been opened was an opened date and was not		preparing, distrib	outing, and
	coaled exposin	a the patties to the neezer		serving food und	er sanitary
	environment an	d potential contamination.		conditions.	•
			Ī.	OMIGHNON	
	The findings inc	olude:	:	The Dietary Mar	nager will
	On 4/10/16 at 1	2:15 p.m., an inspection of the		conduct audits of	f the
	vitchen was col	nducted. On the walk-till ough, s		refrigerator, free	zer and dry
ļ	I plactic bir	anf sugar was opserved		storage 5x/week	for 4 weeks
	uncovered Or	inspection of the walk-in neede	١,	to ensure compl	iance with
	a hay of frazen	heet natties was observed	!	policy. Any vari	ances will be
	turns not cooled	t an opened date written on it, ar I, exposing the patties to the	1	corrected and co	ontinued
	: Was not sealed	ment and potential contamination	n.	education provi	ded. The
	ŧ			results of the au	dits will be
	On 4/19/16 at a	approximately 12:30 p.m., an	ε	results of the au	NHA
	2 P.W. Moisrotei	conducted With OSW #10 (Outer		reported to the l	TATTA
}	Ctaff Mambar:	#10, the dietary manager). He ar should have been covered an			i i
	stated the sug	St Stionin have been covered at		and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s	the Mary shoot Page 86 of

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED		
AND PLAN	OF CORRECTION	IDEM ILIONION MONISS.	]			C 04/21/2016	
:		495109	B. WING		ET ADDRESS, CITY, STATE, ZIP CODE	1 0-10	
NAME OF	PROVIDER OR SUPPLIE	R	Ì		PEMBERTON RD		
ł .	URELS OF UNIVERS				HMOND, VA 23233		
INELA			ID	<u></u>	SPOYIDER'S PLAN OF CORRECTION	DN DRE	(X5) COMPLETION
(X4) ID PREFIX TAG		STATEMENT OF DEFICIENCIES JCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREF TAG	IX S	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	PRIATE	DATE
			: E	371	Continued compliance will	be	
F 37	1 Continued From	page 86	. '	311	monitored through the		
	the patties shoul	d have been dated and sealed.		i	facility's quality assurance		•
		quested regarding these		:	program. Additional		1
	concerns.		<u> </u>	:	education and monitoring		•
·	A review of the r	policy that was provided,			be initiated for any identifi	ed	
	I urbanalulad and	Storage Safety", did not address disealing of food products.	1		concerns.		:
	÷				Completion Date:		1
	On 4/20/16 at 6	22 p.m., the Administrator was the findings. No further	:		May 26, 2016		:
1	made aware of	provided by the end of the		1	, , , , , , , , , , , , , , , , , , ,		*
	survey.	, , , , , , , , , , , , , , , , , , , ,					
1							
		- I Day Code 2013 documents:					
		nd Drug Code 2013 documents:		1			
	EOOD ====koo	se chall he in 0000 container and		1			1
1	i wastoot the inte	arity of the contents so that the		:			
	FOOD is not e	xposed to ADULI ENATION of		· .			:
	- stantial conta	minants.		F 412			:
F4	12 483.55(b) ROU	JTINE/EMERGENCY DENTAL	;	. !			•
ss	=D SERVICES IN			1			:
	The nursing fa	cility must provide or obtain from		į			
	nutride rec	MIRCA IN ACCORDANCE WITH					
	0.400 75(h) of	this nart routine no the extent					
	covered under	the State plan); and efficiency	1				
	identi muci	if necessary, assist the resident	t in				:
	1	atmonts' and by all allully ivi			İ		
	4 annonartation	to and from the delitions of thee, t	and				İ
ļ	must promptly	refer residents with lost of	ļ Ļ				:
	damaged der	tures to a dentist.			-		:
					1		 
1	This REQUIR	REMENT is not met as evidenced	Ė				
	11		!				
	Based on re	sident interview, staff interview,			<u> </u>		

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:					С
		495109	B. WING			04/	21/2016
	PROVIDER OR SUPPLIER			242	REET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF UNIVERSI		·	KJC	CHMOND, VA 23233 PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	(EXOL) DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	TD RF	COMPLETION DATE
F 412	Continued From p	age 87	F	412	F Tag 412		
	review, it was dete	eview and clinical record ermined that the facility staff ental services for two of 29	·	:	Resident #12 complaine	d of	:
	residents in the su	rvey sample, Resident #12 and			tooth pain during the sur Resident #12 had receiv	ed	
	6.  1. The facility sta	ff falled to provide/obtain timely			dental services prior and appointment was made		
	dental services to cracked tooth.	r Resident #12, to address a			following the survey. However, resident refus stated his pain was reso	ed and	
	2. The facility standard services to Resid	ff failed to provide timely dental ent #6.			Resident will receive se in the future as needed.	rvices	:
	40/4//13 with dia	was admitted to the facility on	:		Resident #6 had dental services prior to survey will be offered services	and as	
	not limited to, C\ stroke), HTN (hy pressure), hyper blood stream), h hypercholestere	/A (cerebral vascular accident - pertension - high blood lipidemia (elevated lipids in the emiplegia, depression, and mia. most recent MDS (minimum dat			Residents needing dent services have the poter be affected by this practices.	ntial to	:
	set) was a quart	erly assessment with an AND reside to the residence date) of 3/2/16. Reside	- 1		An audit will be comp	leted on	
	#12 was coded (Brief Interview of 15. The MDS of 15 indicates t intact.	on the MDS as naving a blins for Mental Status) score of 15 o 5 manual documents that a scor that the resident's cognition is	ut re		residents to identify if have a need for dental that have not been add	services	
	was under Med		t				: :
	A review of Res revealed, in par	sident #12's clinical record rt, the following physician notes:		_:::	To No. 10 March 15 April	ntinuation sh	neet Page 88 of 12
		reigns Obsolete Event ID: H	82911		Facility ID: VA0249 If cor	mituadon, Si	

		& MEDICAID SERVICES	(X2) MULT	PLE CC	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
ANDFLANC	00101-01-0					04/21/2016
		495109	B. WING_	DEC	ET ADDRESS, CITY, STATE, ZIP CODE	0-1/2010
NAME OF P	ROVIDER OR SUPPLIER				PEMBERTON RD	
THEIAII	RELS OF UNIVERSI	TY PARK			-IMOND, VA 23233	
THE EAC			ID	<del></del>	PROVIDER'S PLAN OF CORRECTIO	ON (X5)
(X4) ID PREFIX TAG	ACT OF DEELOIGNO	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	<b>&lt;</b>	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
				1	The NHA will in- service	
F 440	Continued From p	ane 88	F 4	12	social services staff on	
F 412	NADIALE DE Instit	ent) requests visit today r/t			providing medically - relat	ted
	: (related to) right to	ioth "ache" x 2 days.	:		services to attain or mainta	in
	Accessment and F	Plan: cracked tooth, acute.			the highest practicable	
	Nursing to schedu	le Dentist appointment."	<u> </u>	<u>:</u>	- physical, well-being.	
<del> </del>	<u>- "1/18//16.</u> Interva	history: Reports mouth lurse spoke to pt's (patient's)		-	bitty orders,	•
	inan rogarding der	ital annt (abbointment).			The Social Services Direc	tor
	i Awaiting can to m	ake dentai addi. Assessinem	1		will audit residents with n	eed
	i and alon: Toothai	che R (right) antenoi- origorig-	i.		for services weekly for 4	·
	Ctaff to cohodule	dental appointment asay (as			weeks to ensure timely	
	soon as possible)	after checking with family re-	:		appointments are made to	)
	preferred provide	r."	<u>l</u>		= :	
	Eurthar review of	Resident #12's clinical record	İ		maintain well- being. Rest	ilts
	did not reveal any	nursing notes or social service			will be reported to the NH	Α.
1	notes that eviden	ced that Resident #12 had			Any variances will be	
	received dental s	ervices.	1		corrected and continued	<b>,</b>
			:		education provided.	•
	A review of nursi	ng notes for Resident #12 that Resident #12 had received	ł			
	noin medication :	for documented toothache on in	ie		Continued compliance wi	ll be
	following dates:	12/10/15; 12/16/15, 12/20/15,			monitored through the	
	4/25/46: 3/21/16	3/23/16: 3/24/16: 3/20/10:			facility's quality assurance	e
	3/26/16, 3/27/16	4/18/16 and 4/19/16.			program, Additional	
			į		education and monitoring	g will
	On 4/20/16 at 10	0:00 a.m. an interview was Resident #12. Resident #12 was	s		be initiated for any identi	ified
	ankad whether (	or not he had seen a deriust.			concerns.	
	D1-dont #12 cf	ated that he had seen one on	į		Concerns.	•
	2/10/16 because	e of toothache. Resident #12 wa	as I		Completion Date:	:
	acked whether (	or not he continued to have			May 26, 2016	•
	problems with the	ne tooth, Resident #12 stated the	1		May 20, 2010	-
	he was suppose	ed to go back and have the tooth cted. Resident #12 stated that the	he l			1
	in the had broke	n and the dentist couldn't just by	un			:
	Lucianth Dock	dant #17 was asked wilduid of	!		•	:
	in at he continue	A to have problems with the look	Li is :		•	:
	Resident #12 s	tated that it hadn't bothered him				
	too_much					nuation sheet Page 89 of

	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:			C 0 4/2046	
		495109	B. WING		04/21/2016	
NAME OF B	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP	CODE	
				420 PEMBERTON RD		
THE LAU	RELS OF UNIVERSI	TY PARK	R	RICHMOND, VA 23233		
(X4) ID PREFIX	ACA OUL DEFINITION	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  NECESTRESTANCE (NECESTRESTANCE)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	HE APPROPRIATE DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		DEFICIENCY		
Xv			2	1		
F 412	Continued From p	age 89	F 412			
		40 a.m. an interview was		<i>i</i> : : : : : : : : : : : : : : : : : : :		
	andusted with R	N (registered nurse) #4, the unit	t	:		
	managar RN #4	was asked whether of not their	<u> </u>	1		
	· wac-s-consult red	tiest for Resident #12. KN #4				
	- measod that che di	d not know. KN #4 was asked				
	whather or not Re	esident #12 had seen a dentist.				
	PN #4 stated that	she thought he had seen a	ė.	• •		
	dontiet RN #4 W	as asked when Resident#12	¬ <b>f</b> !			
	<ul> <li>saw a dentist and</li> </ul>	I to provide the documentation	J1 :	1		
	the dental visit. F	RN #4 was unable to locate any				
1	documentation a	nd stated, "If the resident didn't			:	
	-: bring anything ba	ick from the visit we wouldn't		i I	•	
	have anything."	RN #4 was asked what the	į s		i i	
	responsibility of t	he nursing staff was to	ld		· •	
}	determine the plant	an of care for a resident who ha				
ł	been on a consu	It visit. RN #4 stated, "We			<u>:</u>	
	should have call	ed to follow up." RN #4	1	1		
	requested more	time to gather information.				
	0 4/00/4/2 =± 4/	2:45 p.m. RN #4 stated that she	:	i	:	
1	On 4/20/16 at 14	entist and that he had "no	1			
1	nad called the u	ns". RN #4 was asked to provid	le	:	•	
	recommenualion	or note from the dentist that		: 	į.	
	a consult street	no further care required. RN #	4 !	1	Ť.	
	atatad aha did n	of have it but would try. INN ##	1		: :	
	who solved who	was responsible for resident co	ıre,			
	DN #4 recoonds	24. "Milises of the unit make or	11 <del>-  </del>		· · · · · · · · · · · · · · · · · · ·	
	that the medical	fings and treatments are provide	Gu ļ		:	
	and that ADI (a	ctivities of dally living) are upine	•			
	Nurcos are also	responsible to make suite man	ļ	1		
	habitaian order	s are followed and that the				
	- Franklant case th	ne physician when necessary		•		
	DN #4 was ask	ed what is documented when a				
	regident leaves	the facility for a consult. Riv #*	4 !			
	rocponded "Th	e night shift nurse gets the	1 1	:		
		ty for the appointment and				
]		urees document when the resid	ent '		•	
l	leaves the facil	ity. We did not document anyth	nng :		If confinuation sheet Page 90 o	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495109	B. WING			04	/21/2016
	ROVIDER OR SUPPLIER			STRE 2420	ET ADDRESS, CITY, STATE, ZIP CODE PEMBERTON RD HMOND, VA 23233		
IHE LAU		The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon		1001	DROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	ANT ALL PERIOR MO	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUILL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	COMPLETION DATE
			=	412			•
F 412	Continued From p	age 90	Г	412:			
	when (name of Re	esident #12) when to see the					
1	dentist "RN #4 W	as asked what other					:
ļ	documentation wo	ould be included when a	<u> </u>				
	resident goes out	of the facility on an #4 responded, "There should					
	appointment. For	when they return, we would					
į	Hoolymont the time	e of refurn and whether of hor					
	thoro are any new	orders." RN #4 was asked					:
	bother or not thi	s was done for Resident #14.					
	DN #4 stated it W	as not done. RN #4 was asked					
	in hather or not Re	asident #12 needed to do pack					
	to the dentist, RN	#4 responded that she did not					
	know.		•				
	0 1/20/16 at 1:0	00 p.m. an interview was					
	: aanducted with 1	PN (licensed practical nurse)					
	#40 I DN #10 st	ated that she worked will					
	Dident #12 the	day following his defital					
ŀ	later out and	that he (Reside!) # 141 Hay love					
	har that he need	ed an extraction, LPN #10 was					
	ankad whathar a	r not she documented allytimig					1
Ì	or followed UD W	ith the dentist that Resident #12		:			
	had soon IPN:	#10 responded that she had		:			; -
1	talked to his (Re	sident #12's) son about getting		1			
Ì	another appoint	ment. LPN #10 was asked he followed up and she stated	;	1			1
İ	whether or not s	LPN #10 was asked what she	:	i			:
1	that she did not.	ne to ensure that Resident #12	<u> </u>	:			:
	received the nec	cessary treatment. LPN #10		:			i .
	i skewed that ahe i	ehould have followed up of	ļ.				
	involved social s	services to get Resident #12 the	1				;
	treatment he ne	eded.	!				:
		the #4.00 core plan dated 0/1/	15				:
	A review of Res	sident #12's care plan dated 9/1/			:		
1	and reviewed o	n 3/9/16 revealed, in part, the					;
	following docum	mentation: "Onset/DC 12/28/15. Problems/Conclusion:	s:		•		
	(discontinued)	in related to cracked tooth.	:		-		
	Pain: Actual Pa	erventions: Administer					

CENTER	S FOR MEDICARE	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:					c
		495109	B, WING	STR	EET ADDRESS, CITY, STATE, ZIP CODE		21/2016
	ROVIDER OR SUPPLIER		ļ	242	0 PEMBERTON RD		
THE LAU	RELS OF UNIVERSI		- Day - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20	RIC	CHMOND, VA 23233  PROVIDER'S PLAN OF CORRECT	CTION	(X5)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JULD BE	-COMPLETION DATE
		04	F	412			
F 412	Continued From p medications for pa effectiveness (sig)	ain and observe for )/side effects and report		:			•
	ineffectiveness to				_		
	p.m., ASM (administration facility administration for manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were manager; were mana	40 a.m. ASM #1 was interviewed "We are still trying to get on the dental appointment. We ng is documented and we know as not done."	g ie				
	conducted with social worker. ( was in regards to responded that dental appointm OSM #2 was as responded, "I had issues. He never	:05 a.m. an interview was OSM (other staff member) #2, OSM #2 was asked what her roto dental appointments. OSM she did not get involved with ments unless there was a problem about Resident #2. OSM and no idea about his dental er mentioned dental issues to resident.	#2 #2 #2 me."				
	No further infor end of the surv	rmation was presented prior to ey process.	the				
	The facility     dental services	staff failed to provide/obtain tin s for Resident #6.	nely				theet Page 92

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		3		C /21/2016
	ROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP 2420 PEMBERTON RD RICHMOND, VA 23233		12112010
THE LAU	RELS OF UNIVERSI		lD	DROVIDER'S PLAN OF C	ORRECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	CAOU DEDICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	HE APPROPRIATE	DATE
F 412	with diagnoses ind Bipolar disorder, significant change (assessment referenced as having for making daily of 15 on the BIMS status). She was On 4/20/16 at 8:10 observed sitting resident smiled, had multiple chipattempt to intervistatus was unsurnonsensical responsensical responsensical responsensical nurse). "Guest commendut that she only dietician) made	admitted to the facility on 5/7/11 cluding, but not limited to: seizure disorder, Schizophrenia, isease, and depression. On the (minimum data set), a e assessment with ARD rence date) 2/10/16, she was moderate cognitive impairment decisions, having scored nine of (brief interview for mental coded as having broken teeth.  10 a.m., Resident #6 was up in bed in her room. When the surveyor observed that she uped/broken/missing teeth. An ew the resident about her dental coessful due to Resident #6's conses.  dent #6's clinical record revealed written 11/12/15 by LPN (licensed #1. The note stated, in part: inted that she eats all of her food y has one tooth. RD (registered aware and diet downgraded to	at le	2		
	by OSM (other dietician, on 12)	revealed the following note writte staff member) #1, the registered /2/15: "Diet has been liberalized lithy and texture has been chanical soft due to poor	٠,			
	by the nurse pr	revealed the following note writt actitioner on 12/11/15: "[Reside culty chewing, no difficulty rdered dental consult." The rec	511L ]		if continuation s	heet Page 93 of 1

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				,	21/2016
	ROVIDER OR SUPPLIER		B. WING	STF 242	REET ADDRESS, CITY, STATE, ZIP COL		2 1/2010
THE LAU	RELS OF UNIVERS	TATEMENT OF DEFICIENCIES	ID PREF	<u> </u>	CHMOND, VA 23233  PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION
PREFIX TAG	ACAOU DEDICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	DATE
F 412	Continued From p	page 93	F	412			
	practitioner actua	o evidence that the nurse lly ordered the consult, and iew the nurse practitioner during	:				
	the survey were u	insuccessful.	-				
	on 2/9/16 by OSN	vealed the following note written  #2, the social worker: "Guest king to have residents (sic) teeth has Medicaid and I provided a	1				:
	number to the un dentist] to call an	it manager for [name of local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution of the local distribution o	:				
	part, the following 156.4; 1/4/16 - 1 146.8; 4/4/16 - 1 interventions by	dent #6's weights revealed, in g: 11/5/15 - 157.4; 12/1/15 - 55.8; 2/7/16 - 143; 3/1/16 - 47. The review revealed multiple the facility staff to address sight loss, including double s and dietary supplements.	<b>Э</b>				
	following note w 3/18/16: "Weight self-restricting d	slinical record revealed the ritten by the nurse practitioner or the loss over several months due let to fruit and cottage cheese sues. Brother took her to DDS and she had #7 and #26	to .				
	Resident #6 dat	comprehensive care plan for ed 2/22/16 revealed, in part, the ration in dental status related to: teeth missing, arious teethDental consults as	1				
	staff member)	i:50 p.m., ASM (administrative #1, the administrator, ASM #2, th ing, ASM #3, the regional quality nager, and ASM #4, the regional	/				pet Page 94.0f 1

STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIENCES (X2) MULTIPLE CONSTRUCTION			E SURVEY				
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	1		CON	COMPLETED	
VAIN I PULL			= : :== ::		ļ	c (	
		495109	B. WING		04	21/2016	
		755100		TREET ADDRESS, CITY, STATE, ZI			
NAME OF F	PROVIDER OR SUPPLIER			420 PEMBERTON RD		}	
THELAU	RELS OF UNIVERSE	TY PARK		RICHMOND, VA 23233			
11111111111111				PROVIDER'S PLAN OF	CORRECTION	(X5)	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	/FACH CORRECTIVE ACT	ION SHOULD BE	COMPLETION	
PREFIX TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T	THE APPROPRIATE	DATE	
IAG			1	DEI IOILINO	17		
F 412	Continued From p	age 94	F 412	· ·		•	
' ' '-	manager were info	ormed of these concerns.				}	
1	: Illanager, were init	office of these serves	:	:		į	
	On 4/21/16 at 8:35	5 a.m., OSM #2 was	:			:	
	interviewed regard	ling the process for obtaining	-			:	
	dental consults for	residents. She stated: "I don't	<u> </u>	<u>:</u>	<u> </u>		
<u> </u>	really get involved	in that, If someone needs a	i	1			
ŀ	nhone number or	something, I will get them the				Í	
	number. The nurs	ses do the calling and set the					
}	appointments." W	/hen shown the above		•			
	referenced note (2	2/9/16) and asked what she					
	remembered abou	ut Resident #6's dental situation	7				
	she stated: "The	guest's son contacted me to let	.	1			
	me know." She s	tated that she thought it was the	<b>≯</b>				
	son's job to make	the appointment for the					
	resident. She sta	ted: "I gave the son the	if				
	number." When a	asked if she followed up to see i	11				
	the son made the	appointment in a timely					
	manner, she state	ed, "No I didn't. I assumed he					
	would make the d	all. I gave him the number of a	:	<u> </u>			
	dentist who takes	Medicaid and that's the last I		:			
	heard of it." VVne	on asked if she was aware that	i	: -			
	Resident #6 nad	been losing weight since she stated: "Sometimes I went		:			
	November 2015,	neetings. But now I don't much	'	:		•	
1	to the care plan n	tated she did not have a	!				
	anymore of the Me	eight loss coming up in any					
	discussions with	other staff members. When					
1	asked to review h	ner note again and to explain the	e !	•		1	
	discrenancy betw	veen what she had just told the					
	surveyor (that sh	e gave the resident's son the	i				
	: nhone number) a	and what her note stated (that					
	she gave the pho	one number to the unit manager	- i				
	II PN #11 she sta	ated: "Oh. Well, maybe it was		1	,		
•	the unit manager	who asked for the number. I'm	n ¦	:		1	
	assuming that I t	alked to the unit manager, not	!			:	
	the son " When	asked if she specifically	i				
	remembered a c	conversation with the resident's	. 1			:	
	son about the re	sident's dental needs, she state	ad: i				
	"Now that you m	ention it, not really. [LPN #1]	<u> </u>			1 0 0 1	
l .	the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon			E W. 15-1440040	If continuation she	et Page, 95 of 12	

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	
,				
	495109	B. WING		04/21/2016
			STREET ADDRESS, CITY, STATE, ZIF	CODE
NAME OF PROVIDER OR SUPPL	LIEK		2420 PEMBERTON RD	}
THE LAURELS OF UNIVE	RSITY PARK		RICHMOND, VA 23233	
THE LAURELU OF CHITE			PROVIDER'S PLAN OF C	CORRECTION (X5)
(X4) ID SUMMAR'	Y STATEMENT OF DEFICIENCIES	D PREFI	V (FACH CORRECTIVE ACT)	ON SHOULD BE COMPLETION
`- i \ /EACH DESIC	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T	HE APPROPRIATE
TAG REGULATORT	ON ESCIDENTI TITO IN COMMISSION		DEFICIENC	1
				a.
	0.5	: E/	¥12	ļ
F 412 Continued From	m page 95			
probably broug	ght it up in an evening meeting."	:	•	
			•	
On 4/21/16 at	8:45 a.m., LPN #1 was interviewed	3 '		İ
regarding the p	process for obtaining dental			
services for re	sidents. She stated: "We don't			
have a dentist	who comes here." She stated that	11. j	1	ļ
she becomes	aware of needs for dental services	S .	•	
from residents	themselves or from families. She	<b>⇒</b> i :		
stated: "Most	of our residents are on Medicaid.	*		1
The nurses ar	e responsible for calling the			ţ
dentists and s	etting up transportation." When		:	ł
shown the pro	ogress note from the nurse		:	
practitioner da	ated 12/11/15, she stated: "This is	:	•	
the first time I	'm seeing this. It's just a note.	}	:	
don't see an o	order." When asked what she	ŧ	i	
remembered	about Resident #6's dental consul	L	:	
resulting in to	oth extraction on 3/16/16, she			
stated: "I can	i't tell you. We don't keep the			1
paperwork.	don't know when the appointment			
was actually r	made." She stated she would "do	+		ļ
some checkir	ng" and let the surveyor know wha	ı		
she found out	t, On 4/21/16 at 11:05 a.m., she			Ì
stated: "I dor	n't have any notes or any	r :	:	†
information.	I don't know why it took so long for			1
us to get her	a dental consult."		•	
:	144 40 OCM #1 WOS		i i	,
On 4/21/16 a	t 11:10 a.m., OSM #1 was	115	i	
interviewed r	egarding Resident #6's dental stat	.40.		
She stated:	"We have been following [the	ot :	: 	:
resident] for	some time." She stated she did no	) 		;
recall anyone	e telling her that the resident was			•
having troub	le chewing due to poor dentition.	the		·
She stated tr	nat she had not actually assessed			;
resident face	e-to-face. When asked about the		1	•
physician's c	comment about the resident	ne l		
self-restricting	ng her diet due to dental issues, sh	her i		;
stated: "I wa	as not thinking this was related to	nods		•
dentition. I t	thought she just preferred those fo	, us		. 1
for some rea	ason."		Facility ID: VA0249	If continuation sheet Page 96 of 122
		100044	Faculty II F VALIZ49	II GGIIIIII III II GIII GIII GIII GIII

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  TOTAL PROVIDER/SUPPLIER/CLIA  TOTAL PROVIDER/SUPPLIER/CLIA			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	i	c \
		495109	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO		/21/2016
NAME OF F	PROVIDER OR SUPPLIER	-		2420 PEMBERTON RD	52	
THE LAU	IRELS OF UNIVERSI	TY PARK		RICHMOND, VA 23233	DESTION	(VE)
(X4) ID PREFIX TAG	ALYON DECICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 412	Continued From p	age 96	: F 41	2		:
	Camicocii rovealed	cility policy entitled "Dental d, in part, the following: "The				:
	facility will provide	or obtain from an outside				
	emergency dental each guestIf ned the guest in makin transportation to a promptly referring dentures to a den		d   : :			
F 441	No further information 483.65 INFECTION SPREAD, LINEN	ation was provided prior to exit. DN CONTROL, PREVENT S	F 4	41		
	Infection Control	establish and maintain an Program designed to provide a d comfortable environment and ne development and transmission ofection.	:			
	Program under v (1) Investigates,	establish an Infection Control which it - controls, and prevents infection				
	i should be applied	t procedures, such as isolation, d to an individual resident; and ecord of incidents and corrective o infections.	1			
	(1) When the Indetermines that prevent the spre	Spread of Infection fection Control Program a resident needs isolation to ead of infection, the facility must lent.  The prohibit employees with a	t :			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '	TIPLE CONSTRUCTION ING		OMPLETED
		495109	B. WING		(	C 04/21/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2420 PEMBERTON RD RICHMOND, VA 23233	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 441	from direct contact direct contact will to (3) The facility must	age 97 ease or infected skin lesions t with residents or their food, if ransmit the disease. st require staff to wash their Hrect resident contact for which		F Tag 441  Resident #11 has the held nebulizer store the page 18	ed in a bag	
	hand washing is in professional pract	idicated by accepted	:	when not in use pepolicy.	1 facility	
	(c) Linens Personnel must he transport linens so infection.	andle, store, process and o as to prevent the spread of	: 1	Residents receivin treatments have th to be affected by t	e potential	
	by: Based on observed document review was determined to store respiratory of prevent infection survey sample, R	l's nebulizer treatment bserved not covered or stored i	n –	The Unit Manager complete rounds of weeks to ensure storage of nebuliz equipment. Any was be corrected and education provide results of the audiceported to the Desirable complete to the Desirable complete.	5x/week for proper yer ariances will continued ed. The its will be	1
	The findings inclu					
	3/28/16 with diag	s admitted to the facility on moses that included but were no ed right hip, respiratory fallure, nonia, neurogenic bladder and a cancer.				
	assessment, an	MDS (minimum data set) admission assessment, with an erence date of 4/4/16, coded the				

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
TATEMENT ( ND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:				C	12046
		495109	B, WING		ET ADDRESS, CITY, STATE, ZIP CODE	04/21	/2016
NAME OF P	ROVIDER OR SUPPLIER			2420	PEMBERTON RD		
THE LAU	RELS OF UNIVERSI	TY PARK		RIC	HMOND, VA 23233  PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	X	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	INTERE ,	DATE
F 441	Continued From p	age 98 g a 14 on the BIMS (brief al status) indicating the resider		441	The DON and ADON wi	11	
	abla of m	aking dally cooplilive decisions.		<u>.</u>	licensed staff on proper storage for nebulizer		
	Resident #11 was	or more staff members for all of ally living except eating in which	of		equipment to ensure sani and infection control.		
	#11's nebulizer to observed on top plastic bag. The machine. The ne	on one of the data of the dresser, not stored in a mask was just resting on the bulizer equipment was again 0/16 at 8:05 a.m., 12:49 p.m. at the pebulizer	nd		Continued compliance we monitored through the facility's quality assurant program. Additional education and monitoring be initiated for any iden	nce ng will	
	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa	each observation the nebulize not covered or stored in a plasti	, :	- -	concerns.		
	"Budesonide (be called corticoste swelling and irrit easier breathing (milliliters) Susponebulizer twice				Completion Date: May 26, 2016		
	1 1 1 1 1 1 1 1	ident #11's MAR (medication ecord) for March and April 2019 nentation the medication was sordered.	6				
	documented, "I difficulties r/t (r episodes of sh "Approaches" ( medications &	nsive care plan dated, 4/12/16, Problems: Potential for respirat elated to) history of bronchitis a ortness of breath." The documented in part, "Administe treatments per physician order ectiveness, side effects and ons of medications and treatme	and er			ontinuation shee	

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

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND	PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		(	
			495109	B. WING			1	21/2016
	ME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		}
1						20 PEMBERTON RD		Ì
11	HE LAU	IRELS OF UNIVERSI	TY PARK		R	ICHMOND, VA 23233  PROVIDER'S PLAN OF CORRECTION	NC	(X5)
F	(X4) ID PREFIX TAG	ACT OF DECIDIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.DBE	(X5) COMPLETION DATE
				·-	4 4 4	·		
	F 441	Continued From p	age 99	F	441	i		:
		and report abnorn	nal findings to physician."			i i		
		will are in the room	for a wound observation with					
		I DNI /linemand pro	actical nurse) #12, 00 4/20/10 at	:		1		-
+		: 4.20 n m 1 DN #1	2 was asked what was wrong	•		1		
		with Resident #11 LPN #12 stated, '	's nebulizer mask and tubing,	i				
								:
		An interview was	conducted with administrative	1				· \
		staff member (AS	SM) #2, the director of nursing,					[
		on 4/20/16 at 1:5	8 p.m. When asked where a ent apparatus is stored, ASM #2			:		ļ
		: 11 A	SINORI'S NEUSINE VVIIELI BONCU					
		how the apparati	is is stored, "Bagged and dated	," : .				į
		An interview was	conducted with ASM #3, the					. [
		Designal OA (all	ality assurance Manager) on	er [[]				.
		4/20/16 at 2:04 p	o.m. When asked how a nebuliz atus is stored, ASM #3 stated,	.01				
-		"Stored in a bag	, labeled and dated."	:				
								:
		The facility polic	y, "Aerosol Treatments" 3. Disassemble hand held unit,					
		shake dry and p	lace in bag."					!
		;						<u>.</u>
		In "Fundamenta	als of Nursing" 7th edition, 2009: ar and Anne Griffin Perry: Mosby	, /,				
+		Inc. Dage 648	"Rox 34-2 Sites for and Cause	s				
		of Woolth Care-	Associated Intections under	i i				
		Respiratory Tra	ct Contaminated respiratory	:				į
		therapy equipm	ent." tor, ASM #2, ASM #3 and ASM	#4,				
		the regional ma	inager, were made aware of the	•		:		
		above findings	on 4/20/16 at 6:18 p.m.			:		:
		l.	mation was provided prior to ex	cit.				
		:		:				
			ation was obtained from the					
	<u></u>	website:	Front ID:	182911		Facility ID: VA0249 - If contin	uation-she	et-Page-100 of-12

Event ID: H82911

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	COMPLETED
	495109	B. WING		04/21/2016
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF UNIVERSIT		242	REET ADDRESS, CITY, STATE, ZIP CODE 20 PEMBERTON RD CHMOND, VA 23233	
VEACH 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 APPRODEFICIENCY)	D BE COMPLETION
ds/a699056.html	n.gov/medlineplus/druginfo/me	F 441		
If the facility does in professional person to be provided by that service for person or agency carrangement description.  Act or an agreemed (2) of this section.  Arrangements as the Act or agreement furnished by outsing that the fact obtaining services standards and pringer professionals provided and the timeliness.  This REQUIREMING by:  Based on staff in complaint investig the facility staff far agreement for description for not by ASM (administration).	not employ a qualified in to furnish a specific service the facility, the facility must surnished to residents by a coutside the facility under an ribed in section 1861(w) of the ent described in paragraph (h) described in section 1861(w) of ents pertaining to services de resources must specify in cility assumes responsibility for that meet professional inciples that apply to widing services in such a facility of the services.  ENT is not met as evidenced terview and in the course of gation, it was determined that illed to maintain a contractual intal services.  Ide:  Sility's state department of healt arsing home license completed trative staff member) #1 (the		A contract has been established for routine and emergency dental services meet the needs of each guarded to see the potential to be affected.  The Social Services Direct will audit residents with new for services weekly for 4 weeks to ensure timely appointments are made to maintain well-being. Rest will be reported to the NHAny variances will be corrected and continued education provided.  NHA will provide education to social services departments on coordination of dental services and contractual arrangements.	tor eed  ults A.
name of the facil	ator) on 10/12/15 revealed the ity's dental consultant.			

Facility ID: VA0249

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

CENTERS	NTERS FOR MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & MEDICARE & M	(X2) MULTIPLE CONSTRUCTION				COMPLETED	
FATEMENT O	F DEFICIENCIES	IDENTIFICATION NUMBER:	A. BUILD	ING			
AD BLAN OF	CORRECTION  A95109  OVIDER OR SUPPLIER  RELS OF UNIVERSITY PARK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 101  On 4/19/16 at approximately 11:45 a.m., duri the entrance conference, ASM #1 was aske provide all contracts for outside services.  On 4/20/16 at approximately 10:35 a.m., AS was asked to provide all facility dental contr On 4/20/16 at 11:07 a.m., an interview was conducted with LPN (licensed practical nurs LPN #1 stated no dentist comes to the facil LPN #1 stated residents only go out to a de as needed and it's hard to find a dentist tha accepts Medicaid residents.						21/2016
		495109	B. WING		OTALE ZIP CODE		
	- CURRITER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
				2420 Pt	EMBERTON RD		\
TUE LAUF	RELS OF UNIVERSI	TY PARK		RICHN	MOND, VA 23233	30N1	(X5)
1117 6,40,			ID		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(X5) COMPLETION DATE
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFOLITION  TY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREF	FIX 	(EACH CORRECTION ACTION OF THE APPRICAL CROSS-REFERENCED TO THE APPRICAL CROSS-REFERENCY)	OPRIATE	DATE
	ype atteriology barrens all produces and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the		1	]			
	- u dEnomor	22ge 101	; F	500	Continued compliance w	ill be	:
F 500	Continued From F	Jage 101	:	1	monitored through the		
	the standard mately 11:45 a.m. during		!	:	facility's quality assuran	ice	
		CATARCE ASIVINTI WAS ASILE		<u> </u>	program. Additional		
	the entrance con-	cts for outside services.			education and monitorin	o will	
				-	education and moment	tified	
	On 4/20/16 at an	proximately 10:35 a.m., ASM #1		:	be initiated for any iden	ULLIVU	
	: was asked to pro	vide all facility dental contracts.		I	concerns.		:
		.oz a m. an interview was			Completion Date:		
			1.		No. 26 2016		
				•	May 26, 2016		
	وحوالم سنقسط فيوا ومسا	saidente nniviou our lo a deriae.					
	LPN #1 stated in	t's hard to find a dentist that	i	1			:
	as needed and i	id residents.	ì				
			:				:
	On 4/20/16 at 2	:15 p.m., ASM #1 stated the					
			e				
		- waar brownen services for sir	!	i !			
			ne l				_
			v/I				:
							:
	الانتصطاعة السيايين	CALIFA DEDVICE A HOLD GOLDS		į			:
	i de a fosilita	The list blovided by Aerri	:	1			•
1		e name of two dentists.	į				:
.	: - 404440 mt !	2:25 p.m., ASM #1 was made		1			i
1			M				1
				İ			Ì
1				j			1
	there was one	group of dentists but they would	an't ¦	[			
	accept Medica	aid residents.					1
}			ovit	ļ			
	No further info	ormation was presented prior to	CXII.				i
		DEFICIENCI	į	F 502			!
-	502 483.75(j)(1) A	DMINISTRATION	1	, 556			1
l.			1				:
53	The facility m	ust provide or obtain laboratory	The !				
	services to m	eet the needs of its residents.	,				neet Page 102

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STATEMENT C	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:				С	
AMD I DILL C.						_	1/2016
		495109	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	Q-FF AL	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
NAME OF P	ROVIDER OR SUPPLIER		ļ		20 PEMBERTON RD		
		TV DARK			CHMOND, VA 23233		
THE LAU	RELS OF UNIVERSI		- 400	KIC	DROVIDER'S PLAN OF CORREC	TION	(X5) COMPLETION
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	\ 						
	Continued From p	ane 102	F	502	F Tag 502		
F 502	Continued thom b	ole for the quality and timeliness					
	tacility is responsi of the services.	Die for the quanty area are			Resident #2's physici		
	Of the services.				notified of missing la	bs, new	
			:		order received from p	hysician	· -
<b>†</b>	This REQUIREM	ENT is not met as evidenced	1	į	and labs obtained. Re		
	i leve		,		2 received no harm a		:
1	Based on staff in	terview, facility document review	<b>'</b> }		of this practice.		
	and clinical record	d review, it was determined that iled to obtain physician ordered			1		
]	the facility staff fa	or one of 29 residents in the	1		All residents with ord	lers to	:
	survey sample, R	tesident #2,	:		obtain labs have the	notential	
1					to be affected by this	practice.	
	The facility staff f	alled to obtain Resident #2's			to be affected by this	Practical	:
-	laboratory (lab) to	ests ordered by the physician of			CI II. it Managara	xzi11	
-	2/11/16 and 4/11	/16.			The Unit Managers v	VIII	
		t			complete an audit of	Olders	:
	The findings incl				for labs to ensure ph	ysiciani	•
	Donidont #2 Was	admitted to the facility on 4/9/9	9		orders have been fol	lowea.	
	- : D = -!-langt #2'c di:	SANASES INCIDIOED DOL MOIS HOL			Any variances will b	e	i
	- : Parited to a moliqu	ant neonlasm (CallCCL) (1) VI	:		corrected, physician	_	
	- Landy mulches (	ficcue) (7). Nembledia (pararyon	≶)		notification will be a		
į	المفحمات الدوا	SUMINGING RISCHOLD (4) AND			indicated and addition	onal	
		ers caused by damage to the pa consible for language control) (5	). ·		education will be pr	ovided.	:
	of the brain rest	onside of language comment	<b>'</b> :				:
	: Dorident #2's m	nost recent MDS (minimum data	f I		The DON and ADC	N will in-	:
	is a simplificat	A Abande III SIRIUS doogooiiiciii			service licensed state		
		seasement refer blice date. Of			obtaining labs for re		
	COOKE SOCO	the reginery's Countillon as Pon's	f2		per physician order	s in a	
	- Impoir	ad Section to coded Nesidenia	, _		timely manner to er	sure	
	requiring eV	ensive assistance of one stall "			quality of care.	A. P. T	
	Cootie	ansfers, dressing and personal on G further documented the			quanty of care.		1
ŀ	hygiene, Section	ed supervision and set up help v	vith				1
		au dupor rioier, arra a a a f					1
	eating.						
	A physician's o	rder dated 2/11/16 documented	an				
	order for a CB	C (complete blood count) (6) an	u		Facility ID: VA0249 -If co	ntinuation-shee	t-Page_103 (

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CARE & MEDICAID SERVICES

PRINTED: 05/05/2016 FORM APPROVED
OMB NO. 0938-0391
(x3) DATE SURVEY

ENTER	NTERS FOR MEDICAKE & INICOSOTED DELI	& WEDICAID SEIVOSES	(X2) MULTIPLE CONSTRUCTION				COMPLETED		
ATEMENT	OF DEFICIENCIES	IDENTIFICATION NUMBER:					C		
D PLAN OF	Continued From page 103  CMP (comprehensive metabolic panel) (7) with the next blood draw. A physician's progress not dated 2/11/16 documented a rash on the resident's left arm but failed to document the specific reason for the ordered laboratory tests.  A physician's order dated 4/11/16 documented order for a CBC and CMP with the next blood draw. A physician's progress note dated 4/11/documented in part, "Follow up labs next blood draw. Not done as ordered 2/16"  Review of Resident #2's clinical record failed reveal laboratory test results for a CBC or CM during February 2016 or April 2016.  Resident #2's comprehensive care dated 3/1' documented, "Unable to tolerate nutritionally adequate PO (by mouth) food and fluids result in need for tube feeding4/20/16- Labs as ordered, Report abnormals to MD (medical doctor)"  On 4/20/16 at 12:58 p.m., LPN (licensed pranurse) #1 confirmed the above requested lat were not obtained. LPN #1 was asked the for process for obtaining physician ordered labs LPN #1 stated nurses are supposed to transithe order into the computer system and the log. LPN #1 stated the 2/11/16 order for labs and the computer system and the log. LPN #1 stated the 2/11/16 order for labs and the states are supposed to transit the order into the computer system and the log. LPN #1 stated the 2/11/16 order for labs and the states are supposed to transit the order into the computer system and the log. LPN #1 stated the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2/11/16 order for labs and the 2								
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IAME OF P	ROVIDER OR SUPPLIER				PEMBERTON RD				
					IMOND, VA 23233				
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		402	F	502	The Unit Managers	will audit	•		
F 502	Continued From p	page 103			new admissions an				
	CMP (comprehen	isive metabolic pariel) (7) will			:				
	: the payt blood dra	aw A novsician's progress not	1		orders 5x/week for		•		
		SUMANTER A LASTI UR IIIC	:	:	ensure physician or				
	resident's left arm	put talled to document the	<u>;                                    </u>		followed_timely. A		<del></del>		
				:	variances will be c	orrected			
	A tout-toute and	er dated 4/11/16 documented a	n		and physician notif	fication is			
	· · · · - CDC ·				made along with co	ontinued			
		sala aradress note dated Trivia	3	:	education. The res	ults of the			
	Janumanted in n	ISIT "FOILOW UP ISDS HOVE PIECE	Ì						
	drow Not done	as ordered 2/16"			audits will be repo	rted to the			
					DON.				
	. Review of Resid	ent #2's clinical record failed to	İ	:					
	roveal laboratory	v test results for a CDC of Civil	I	:					
	during February	2016 or April 2016.		:	Continued complia	ance will be			
	· ·		6	1	monitored through				
	Resident #2's co	omprehensive care dated 3/11/1	0	:					
					facility's quality a	220111110C			
	I Loto DO (h	w mouth) tood and halds rooding	uy .	:	program. Addition	nai			
	-1 f - n to 10 0	1444(111 417(11)0- 1400 40	i		education and mor	nitoring will			
	ordered, Repor	t abnormals to MD (medical		1	be initiated for any	y identified			
	doctor)"		:		concerns.	<del>.</del>			
		o so 1 DN (linensed practi	ical	:	AOTIAOTITO!				
}					Commission Datas		,		
	nurse) #1 confi	med the above requestes the	ility		Completion Date:		:		
ļ					May 26, 2016		-		
			ibe .		<u> </u>				
ļ		12124 tha 7/10/10/10/10/10/10/10/10/10/10/10/10/10/							
1	100 1 - AED (0)0	med by a fillise but not duries.	bed						
}		HALANCIAM NUMBER NO.							
Ì	ويوطيم سياليان الأستان	GLOIGH WINTE THE HILLIUMS SIS	er						
ļ	and she (LPN	#1) didn't know if the order was			i		!		
1	"taken off."	•	1				<del>!</del> :		
	į.	^^*							
	On 4/20/16 at	approximately 6:00 p.m., ASM	:						
İ		e staff member) #1 (the ) and ASM #2 (the director of	:						
1	1 1 1 1 1 1 1 1 1 1 1 1 1	and ASM #2 (the director of				If continuation s	10 10		

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

CENTER	S FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	CONSTRUCTION	COMPLETED		
	OF DEFICIENCIES	(X1) PROVIDERSON ELLINGER:	A. BUILD	ING		(	c \	
AND PLAN OF	FCORRECTION	,				04/	21/2016	1
1		495109	B, WING		TATE ZIP CODE			}
1				STF	REET ADDRESS, CITY, STATE, ZIP CODE		ļ	
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F 502	Continued From	Jage 10-		:				
l l	nursing) were ma	ade aware of the above findings.						
1	11	titled, "Lab Scheduling and			: -			
	The facility policy	cumented, "Policy: The facility  - bodying and Tracking Log or	<del></del>		:			
·	Tracking Log ou	Scheduling and Tracking Log or					· · · · · · · · · · · · · · · · · · ·	- -
	will use the Lab	Scheduling and Tracking Scheduling and the acking format to ensure that the ping a system for tracking lab					:	}
1	an automateu u	ning a system for tracking lab	!					\
1	test collection ar	nd physician	:					}
1	test contection Pro	nd physician cedure: 1. The Lab Scheduling county he placed in the front of the			:			
1	and Tracking LC	og will be placed in the front of the The charge nurse (usually the	ie					1
	lah notebook. 2	The charge nurse (usually the						\ \
ł	night nurse) rec	ords on the form each lab that is	3		1			\
1	to be collected.	The nurse will record the date,	rae		:			
1	quest's name, a	and test to be done. 3. The character register to be done.	90		<u>:</u> :			
Ì	nurse (usually t	the night nurse) should validate	lab					1
1	daily the compl	the night nurse) should value eted lab request forms with the	at '		:			
1	calendar to ens	eted lab request forms that sure that all labs required for that the day is the securisitions. 4. The la	b					-
ļ	day have comp	pleted tab requisitions (men) Will			:			}
ł l	tech (or the nu	rse collecting the pass collect	ed .		:		1	1
1	initial on the lo	g that the specimen was been on the date indicated. 5. The number of the test will initial that the	ırse		:		3	
1	for that guest	esults of the test will initial that t	he					- 1
ļ	receiving the r	esults of the test will industry  are received. 6. The nurse will not the test results and documen	otify		•		į.	
1	test results we	of the test results and documents that the properties of the test results and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and initial on the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the properties and the	t the		:		:	
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	https://www	nim.niii.gov/modiii.ep	· · · · · · · · · · · · · · · · · · ·			continuation	sheet Page 10	15 of 12
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PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

		1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C		
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	The facility mus	t provide or obtain laboratory hen ordered by the attending						
	:		_ :				eet-Page 106-of	

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
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F 504	by: Based on staff into	age 106 NT is not met as evidenced erview, facility document review review, it was determined that ed to obtain a physician order	F 50	F Tag 504  Resident #3's physician notified that labs were	n was
	prior to performing residents in the su  The facility staff of metobolic panel (1 (complete blood or (thyroid-stimulating blood work without Resident #3.  The findings include	a laboratory test for one of 29 rvey sample, Resident #3. btained a CMP (comprehensive )), Lipid panel (2), CBC bount (3)), TSH g hormone (4)) and uric acid (5) t a physician's order for de:		obtained.  Residents requiring labs obtained have the potent be affected.  The Unit Managers will complete an audit of or for labs to ensure physical orders have been follow	tial to  l ders cian
	with a readmission that included but we sclerosis (a nervo the brain and spin paralysis, high bloomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic assessment, a que bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogenic bladdomeurogeni	admitted to the facility on 5/4/98 on on 9/24/12 with diagnoses were not limited to: multiple us system disease that affects all cord (6)), osteoarthritis, gout, and pressure, obesity, er, edema, and seizure disorder MDS (minimum data set) carterly assessment, with an appendicts of 2/13/16, coded the		Any variances will be corrected, physician notification will be madindicated and additional education will be provided in the DON and ADON serviced licensed staff	ıl ded. in -
	resident as being decisions. The reextensive assistate of his activities of moving on the unwheelchair).  Review of the clintest result dated.	ence date of 2/12/16, coded the cognitively intact to make daily esident was coded as requiring nee of one staff member for all daily living except eating and it (the resident had motorized nical record revealed a laborator 12/10/15. The report results of a CMP, lipid panel,		obtaining a physician of prior to obtaining labs following the orders time ensure quality of care.	order and

		(IVA) DROVINER/SUPPLIENCED		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
TATEMENT O ND PLAN OF	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			04/	21/2016
	OVIDER OR SUPPLIER	450105	STI	REET ADDRESS, CITY, STATE, ZIP CO 20 PEMBERTON RD CHMOND, VA 23233		2 1/2010
THE LAUF	RELS OF UNIVERSI	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORE	SMOULU BE	(X5) COMPLETION
(X4) ID PREFIX TAG	・・・・・・・ カーロンスコートリク	ATEMIENT DE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
F 504	Continued From p		F 504	The Unit Managers wil	:W	
	physician order fo			orders 5x/week for 4 w ensure physician order	reeks to s-are	:
	A copy of the physician order was requested from LPN (licensed practical nurse) #1on 4/20/16 at 11:50 a.m. A copy of the physician order was requested from the administrator on 4/20/16. At the end of the day meeting on 4/20/16 at 6:18 p.m. a copy of the physician order was requested		!	followed timely. Any variances will be corre and physician notifical made along with continuous education. The results audits will be reported	ected tion is nued of the	
	p.m. a copy of the physician order was requested from the administrative team.  On 4/21/16 at 8:00 a.m. a yellow sticky note was received that documented, "No lab (laboratory) order for (Resident #3)."		DON.  Continued compliance we monitored through the	e will be	; ; ;	
	practical nurse) When asked the tests, LPN #12 sphysician's orde	s conducted with LPN (licensed #12 on 4/21/16 at 8:25 a.m. process for obtaining laboratory stated, "First you have to have a r. We put the order in the ab (laboratory) comes and draws	!	facility's quality assurprogram. Additional education and monito be initiated for any id concerns.	ring will	
	physician's orde laboratory tests have an order f	ed." LPN #12 was asked if a er was required to obtain LPN #12 stated, "Yes, must rom a physician."		Completion Date: May 26, 2016		
	staff member (a on 4/21/16 at 8 for obtaining la	as conducted with administrative ASM) #2, the director of nursing, :28 a.m. When asked the proces boratory (lab) tests, ASM #2 physician order is required. The quisition slip. The lab is here the product of the process.	SS   			
	The facility pol Log," did not a laboratory test	icy, "Lab Scheduling and Trackir ddress having a physician order s.	for			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DAT COA	TE SURVEY
AND PLAN OF	FORRECTION	IDENTIFICATION NUMBER:	a, Buildin	NG		С
		495109	B. WING_			/21/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 2420 PEMBERTON RD RICHMOND, VA 23233	P CODE	
INELAU				PROVIDER'S PLAN OF	CORRECTION	: (X5)
(X4) ID PREFIX TAG	ACACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	X (EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
			, ,	50.4		
F 504	Continued From p	age 108	F5	504		
	The administrator findings on 4/21/1	was made aware of the above 6 at 12:15 p.m.				
-	(1) A CMP (comp	rehensive metabolic panel) A	:			
	- metabolic nanel is	s a droup of tests that measures	1			i.
į.	<ul> <li>different chemical</li> </ul>	is in the blood. These tests are	İ	•	•	
	Lucually done on th	ne fluid (plasma) part of blood.		:		
	The tests provide	information about your body s				
	∍ chemical balance	and metabolism. They can give	,			
	doctors information	on about your muscles (including	9 1			
	the heart), bones	, and organs, such as the	1			
	kidneys and liver.	This information was obtained				
	from the website:	nih.gov/medlineplus/metabolicpa	1			Ì
		III.gov/mediinopida/metazzanep				į
İ	nel.html.	le is used as part of a cardiac	1			
1	(Z) The lipid profi	to help determine an individual's	3	÷		
1	risk of heart dise	ase and to help make decisions	1			
	about what treati	nent may be best if there is	:			
	borderline or high	n risk. This information was		•		
	abtained from th	e website:				
	https://labtestsor	nline.org/understanding/analytes	/I !			
	inid/tab/test		i			:
	(3) A complete b	lood count (CBC) test measures	3			i
	the following: Th	e number of red blood cells. The	3	1		1
	mhar of white	blood cells. The total amount of	1			
	hemoglobin in th	ne blood. The fraction of the blood	, u			<u> </u>
	composed of rec	blood cells hematocrit. This				
İ	information was	obtained from the website: .nih.gov/medlineplus/ency/article	e/ '	) }		:
	https://www.nim	.hin.gov/mediinepida/onoy/a/tiolo				Ì
	003642.htm	stimulating hormone (TSH) test i	is			
	often the test of	choice for evaluating thyroid		:		
	function and/or	symptoms of a thyrold disorder				
	including hypert	hyroidism or hypothyroidism. Th	is	i !		
	information Was	obtained from the website.				
	https://lahtests0	online.org/understanding/analyte	s/t	į		1
1	abliabliast		1			
	(5) The uric aci	d blood test is used to detect hig	ıh —			
l	(0)		2011	English ID: VA0249	If continuation she	et Page 109-o

STATEMENT AND PLAN OI	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COMPLETED		
			5 14/11/0		0.4/5	21/2016	
	_	495109	B, WING	STREET ADDRESS, CITY, STATE, ZIP CO		21/2010	
ļ	ROVIDER OR SUPPLIER		<b>I</b>	STREET ADDRESS, CITY, STATE, ZIF CO 2420 PEMBERTON RD	.OL	ŀ	
THE LAU	RELS OF UNIVERSI	TY PARK		RICHMOND, VA 23233	DECTION	(X5)	
(X4) ID PREFIX TAG	VEVCH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE	
F 504	levels of this comp help diagnose gou	ound in the blood in order to t. This information was	F 50	4			
F 514 SS=D	uric-acid/tab/test. (6) This information website: https://vsearch.nlmmeta?v%3Aprojectmedlineplus-bund	n was obtained from the n.nih.gov/vivisimo/cgi-bin/query- st=medlineplus&v%3Asources=	, F 5	14		:	
	resident in accord standards and pra accurately docum systematically org.  The clinical record information to idea resident's assess services provided.	d must contain sufficient entify the resident; a record of the ements; the plan of care and t; the results of any reening conducted by the State;	e	F Tag 514  Resident #1's order fleece pad was disconduring the survey. Resident #25 has disfrom the facility.  Resident #9 did not the flu vaccine. The been no harm as a resident was a resident as a resident was a resident as a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a resident was a res	entinued scharged receive re has		
	by: Based on reside facility document review, it was de failed to maintain record for three sample, Resider	IENT is not met as evidenced ent interview, staff interview, treview and clinical record termined that the facility staff in a complete and accurate clinic of 29 residents in the survey at #1, 9 and 25.  Resident #1's clinical record	al	All residents have the potential to be affect practice.	he		

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
VD PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING		) c		
		405400	B WING		04/21/2016		
		495109	STR	EET ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER		1	PEMBERTON RD			
THE LAU	RELS OF UNIVERSI	TY PARK		HMOND, VA 23233			
		ATEMENT OF DEFICIENCIES	ID :	PROVIDER'S PLAN OF CORRECT	OTION (X5)		
(X4) ID PREFIX	ADVICE DEFICIENC	V MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP			
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)			
i		The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	l				
F 514	Continued From p	age 110	F 514	The DON and ADON v	will		
,	revealed that med	ications were administered to	i	complete in-servicing to	0		
	Resident #1 and n	ot documented as		licensed staff on mainta	aining		
	administered.		1	clinical records on each			
	,	- share and over two days not		resident in accordance			
	b. Resident #1 wa	s observed over two days not oad on her right elbow as	:	accepted professional			
	ardered by the ph	vsician while she was up in ner		standards and practices	that		
	wheelchair The 0	documentation indicated that the		are complete; accuratel			
	fleece pad was or	n her right elbow as ordered.		documented; readily	· J		
			1	accessible; and systema	atically		
	: 	ind to document the		organized.			
	2. Facility starrial	led to document the the flu vaccination for the 2015		organizoa.	i ! -		
	through 2016 flus	season in Resident #9's clinical		The Unit Managers wil	; † <b>1</b> :		
	record.			complete an audit 5x/w			
	:			4 weeks of all new order			
	3. The facility sta	ff failed to document in the	:	new admission orders f			
		at Resident #25 was transferred	-	devices to ensure they			
	to the hospital.			documented, new admi			
			:				
	The findings inclu	ude:	;	medication orders alon			
			:	new medication orders			
	1a. Resident #1	was admitted to the facility on	-	documented on the MA	XK.		
	6/10/15 with diag	noses that included, but were /A (cerebral vascular accident -	a	en TT V. S. C. 19	11 1		
	ctroke) HTN (hv	nertension - high blood	i	The Unit Managers wi	· ·		
	nressure) obesi	tv. hyperlipidemia (elevated lipid	8	audit discharge records			
	in the blood stre	am), diabetes, sieep apriea ariu		5x/week for 4 weeks for	!		
	expressive apha	sia (difficulty speaking).	:	clinical documentation			
	B	ost recent MDS (minimum data	1	ensure discharges have	and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s		
	Resident #1's m	erly assessment with an ARD	į.	and nurses notes timel	· •		
	/assessment ref	erence date) of 2/10/16.		variances identified wi	•		
Į	Posident #1 was	s coded on the MDS as naving a	·	corrected and continue	d		
	BIMs (Brief Intel	rview for Mental Status) score of	1	education provided. Th	ne		
	Lout of 15 The I	MDS manual documents that a	}		1		
	score of 7 indica	ates that the resident's cognition	15		<u> </u>		
<u> </u>	severely impaire	sions Obsolete Event ID: H8		acility ID; VA0249If cor	ntinuation sheet Page 111		

	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	DENTIFICATION NUMBER:			1	21/2016	
	AME OF PROVIDER OR SUPPLIER  THE LAURELS OF UNIVERSITY PARK  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 514  Continued From page 111  A review of Resident #1's medication administration records (MARs) for April 2016 a March 2016 revealed, in part, that medications were not consistently signed by a nurse as be administered. The following medications were not documented as being given to Resident # Oxycodone/acetaminophen 5/325 * (used to to pain) was not documented as administered or 3/4/16 at 6:00 a.m.; 3/16/16 at 2:00 p.m.; 3/24 at 10:00 a.m. and 2:00 p.m.; 3/29/16 at 10:00 a.m. Humalog ** (a type of insulin used to treat high tensor to the pain) was not documented as		24	REET ADDRESS, CITY, STATE, ZIP CODE 20 PEMBERTON RD CHMOND, VA 23233  PROVIDER'S PLAN OF CORRECT	ion	(X5) COMPLETION	
PREFIX	マート ない ログログログ	V MIRT RE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE	DATE	
F 514	A review of Reside	ent #1's medication ords (MARs) for April 2016 and	F 514	results of these audits will reported to the DON.	be		
	March 2016 reveal were not consiste administered. The not documented a Oxycodone/aceta pain) was not documented at 10:00 a.m. and 2:00 p.r. Humalog ** (a type blood sugar level administered on Lidocaine Patch documented as 10:a.m.; 3/29/16 10:00 a.m. Baclofen**** (use documented as p.m.; 3/24/16 at and 4/19/16 at 2 Famotidine ***** and acid reflux) administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on administered on	ntly signed by a nurse as being e following medications were as being given to Resident #1; minophen 5/325 * (used to treat sumented as administered on n.; 3/16/16 at 2:00 p.m.; 3/24/16 to 2:00 p.m.; 3/24/16 at 10:00 a.m. or of insulin used to treat high s) was not documented as 3/29/16 at 7:30 a.m.  *** (used to treat pain) was not administered on; 3/25/16 at at 10:00 a.m. and 3/30/16 at at 10:00 a.m. and 3/30/16 at 2:00 p.m.; 3/29/16 at 2:00 p.m.; 3/29/16 at 2:00 p.m.; 3/29/16 at 2:00 p.m.;		Continued compliance wi monitored through randor chart audits by the DON a reported to the facility's quality assurance program Additional education and monitoring will be initiate for any identified concern Completion Date:  May 26, 2016	n and n. ed		
	not reveal any r MAR or in the p medications no	of Resident #1's-clinical-record_d nursing notes on the back of the rogress notes that would explain t being administered.	n				
	p.m., ASM (adr facility administ nursing; ASM #	e day meeting on 4/20/16 at 5:50 ninistrative staff member) #1, th trator; ASM #2, the director of 43, the regional QA (quality nager) and ASM #4, the regional made aware that there were a			ne -	pot Page 112 of	

CENTER	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CON	STRUCTION		(X3) DAT	E SURVEY MPLETED	
STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à				С	
		495109	B. WING					/21/2016	-
ve oc B	ROVIDER OR SUPPLIER				ADDRESS, CITY,	STATE, ZIP CODE			
		my napk			EMBERTON RD MOND, VA 2323	33			
THE LAU	RELS OF UNIVERSI			KICHI	DROVIDER'S	PLAN OF CORREC	CTION	(X5) COMPLETIO	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	(EACH CORRECTED OF CROSS-REFEREN	TIVE ACTION SHO	OULD BE	DATE	
									_   .
F 514	Continued From p	age 112	"F 5′	14				:	
	of modics	ations that were not documented	1						
i	- deministered to	n Resident #1. Abivi #1 was							]
-	asked to arrange	a meeting with several or the						:	
	nursing staff the r	next morning.				·			
		a an interview was							
	On 4/21/16 at 8:0	0 a.m. an interview was PN (licensed practical nurse)							Ì
	1	SE SEVER IN RESULUE HOL							Ì
-	www.nen.au	ministering a medication. Line							
	لطأح استمالت السمينا	at and Maille Willie aw liv							1
	- madications that	were to be administered to the		:				i	ļ
		nare to the WAR UII 1191		:					ļ
ļ	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	a acked What was documented,	:					i	
	: LDNI #45 stated 1	that all meds (Ittedianons) unde						i .	1
1	1 1-1-4-4-6	LAKA CHACKAN AS UBINU							ļ
	inictored	PN #15 was asked dilder what							ļ
Ì	circumstances a	in administration time for a	1						Ì
	medication woul	d be left blank. LPN #15 ne medication was not given	:						ļ
		ident reflised of Sometimes we		•					
	114 than MG 14/6	ANY PIACE & HOLE TO MAL DITIES		4					
	in the second of the second	eamathing in the box of it (the	:	1					
1		CAN ACVINA I PIN #10 WOO							
			<b>₹</b> ;						
	بطم مستنات	solved for a medication, it is in-	_						
	1 D = - i d	ANT THE WIAR ALL SLAUGH I THE							
	gave the medic	ations I don't know now i misse	-						
	not documentir	ng them."							
	- 101140 -15	3:40 a.m. an interview was							
	طاخت در امید د	1 00 43 1 00 43 06801060 00	r	;					
	for alv	ing medications as pulling up in		:					
		naring to the medicalions in the						ı	
	· 1 - 10/le/	SE SEVAN SHILL HOUSEHIGH GREEN '	-,					!	
	i — dianélan	ie following agginistiation, 🕒 🔼	<b>∓3</b> .	:				:	
		CONTRACTOR OF THE INC.							
1	بدائم ما مساده و	what would cause a plant opace	) III	;	:				
		TO STATE OF THE INCUICATION	1 1						
	was not "clicke	#3 stated, Ther the LPN #3 w ed" as administered" LPN #3 w	؛ دی			. If o	entinuation s	heet Page 11	3_of 12

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATI	E SURVEY PLETED
AND PLAN OF CORRECTION		DENTIFICATION NUMBER:	A. BUILDING			С	
		495109	B. WING				21/2016
	ROVIDER OR SUPPLIER			2420	EET ADDRESS, CITY, STATE, ZIP CO PEMBERTON RD HMOND, VA 23233	DE	
THE LAU				RIG	PROVIDER'S PLAN OF COR	RECTION	(X5)
(X4) ID PREFIX TAG	ALVOR DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	COMPLÉTION DATE
		page 113	F	514 :			
F 514	Continued From p	and times where medications	·				1
	were not "clicked"	and times where the desident wed the dates and times and	i				i
	stated that she ha	ad no idea why the spaces were	)				
<del> </del>	blank that she re	membered giving the					:
	medications IPI	√ #3 further stated, "Sometime:	S ! 				
	until after 3:00n.n	n't show medications as missed n., after I am gone. I don't really be an issue with the computer.	/	:			
				;			
	: A review of the 12	acility policy titled "Medication evealed, in part, the following	:				1
	documentation "	Procedure: 10. Initial the	:	Ì			
	i quest's Medicatio	on Administration Record (MAR	() (d				:   
	immediately follo	wing administration. 11. Recor omissions including date, time	u				
	and reason on the Administration R	ie back of the Medication					:
	No further informend of the surve	nation was provided prior to the y.			,		
		n was obtained from the followi	ng (				
	website: https://dailymed aDrugInfo.cfm?a	.nlm.nih.gov/dailymed/archives. archiveid=17971	/fd				
	**This information	on was obtained from the	<u> </u>				
	following websit		in.		· · · · · · · · · · · · · · · · ·		
	fallowing wohel	tion was obtained from the					
	https://www.nlm ds/a603026.htm	ı.nih.gov/medlineplus/druginto/	me				!
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ī			(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION			E SURVEY	
	STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		NG			C	
ļ				B. WING			1	21/2016	
			495109	B. WING		CITY, STATE, ZIP CODE			
ļ		ROVIDER OR SUPPLIER			2420 PEMBERTON	N RD			
	THE LAU	RELS OF UNIVERSI	TY PARK		RICHMOND, VA	Committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the committee of the commit			
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_		*****This informati	on was obtained from the	1	1			<u>:</u>	-
		following website: https://www.nlm.n ds/a687011.html	ih.gov/medlineplus/druginfo/me						
		wearing a fleece ordered by the phase wheelchair. The	as observed over two days not pad on her right elbow as nysician while she was up in her documentation indicated that the n her right elbow as ordered.	e		·			
		a care plan dated the following entr "Onset: 7/7/15. F Potential for impa decreased ADL ( incontinence, de Goals: Skin will Goal LT (long ter Approaches/Inte	dent #1's clinical record revealed of 6/18/15 documenting, in part, by: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Skin: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Problems/Conclusions: Prob						
		and times sitting to rest her right; protector on her p.m.; 4/20/16 at Further review crevealed a POS documenting, in	s observed on the following dates in her wheelchair with a lap tray arm on and there was no fleece right elbow: 4/19/16 at 4:00 11:25 a.m.; 4/20/16 at 4:30 p.m. of Resident #1's clinical record (physician order sheet) part, "active orders (4/1/16 - following order was Description	•					
		"Start: 2/1/16 Er	nd 6/18//17. Active Recertified		Facility-ID: VA0249	If-cont	inuation_she	et Page 115 of 1	22

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	3   O(( 101E015)	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	.   0	OWBLETED
STATEMENT (	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A, BUILD	ING		c \
AND PLAN OF	OO: 11 mo 1.01.		-		,	04/21/2016
		495109	B. WING	CTATE 710		V-Y/ Le Tracy IV
				STREET ADDRESS, CITY, STATE, ZIP	JUDE	ţ
NAME OF P	ROVIDER OR SUPPLIE	:K	Ì	2420 PEMBERTON RD		
<b>ተ</b> ⊯⊑   Δ11	RELS OF UNIVER	SITY PARK		RICHMOND, VA 23233		
			ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5) COMPLETION
(X4) ID		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BE PRECEDED BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL NEW MIST BY FULL N	PREF	" CDOSS_REFERENCED TO TH	E APPROLITIONS	DATE
PRÉFIX	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	)	
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		2000ggr = 300ggm = 6.65gg = 3000ggm = 6.000 = 4.000	_			
E E44	Continued From	page 115	F	514		
F 514		t, flagged (sig) BR3(BC(U) (9				
	11 ~ (~)	WALL BUILT WILLIE III MO LALIGOUS.	ir)	*		
}						1 .
	every shirt every	ne order from (name of physicia	ın) '			
	taken by (name	of nurse)."				
ļ	A roview of Res	sident #1's TARs (treatment				
1	Landada Amadian Y	ecord) for the month of the fe	16	:		7
						:
1			١.			
ļ						
			У			:
1		SKIH AND NICH SHILL OUTLEY 'Y			•	•
1	nalpialed	that the fleece protector was an	ı			
	Resident #1's	right elbow on dayshift.	1			
}						
	On 4/20/16 at	4:45 p.m. an interview was	Υ .			
ļ	ماه تند و احاد د		,			:
<u> </u>	#16. LPN #16	6 was asked who was caring for	i			† •
Ţ	Resident #1 0	on that day. LPN #16 responded caring for Resident #1. LPN #1	6	:		1
1	that she was	hether or not she was aware of a	any			
1	was asked Wi	ment that Resident #1 was to ha	ave			
1		SKI HAG POTORFON IN HELLOUINDUSC.				
<u> </u>				i i		<u> </u>
- 1		TRAIN NEATH IN BC DISCOUNT	ner			
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	:	e checking that the ticent cipe	w			) ! !
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ĺ			ked			1
		+66 HAACA PICOW DAU WAY				:
		Laina an Resident #1. Little	•	•		ı
						3 1
}				•		;
		- wandad that she had tust brown		\$ : !		
	Resident #1	's blood sugar but hadn't notice	G		If continuation	on sheet Page 116 c
1	' L'estaction		.m. 1 100044-			

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	C 04/21/2		
NAME OF P	ROVIDER OR SUPPLIER	495109	S	TREET ADDRESS, CITY, STATE, ZIP CODE 420 PEMBERTON RD		
THE LAU	RELS OF UNIVERSI	TY PARK	R	ICHMOND, VA 23233  PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	WASHINGTON TO	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE CO	MPLETION DATE
F 514	wasn't on IPN#	fleece elbow pad was or 16 added, "It is supposed to be	F 514		<u>.                                    </u>	
	! At this time	PN #16 accompanied uns			i i	
	surveyor to look a her wheelchair in was not wearing to elbow. LPN #16 stated, "(Resident should be discontinued since wear it. LPN #16 documented on the resident. LPN #16 documented as compared as compared to the following document interdisciplinary continued since wear it.	t Resident #1 who was sitting in the dining room. Resident #1 he fleece elbow pad to her right spoke with Resident #1 then t #1) does not want it on, it tinued." LPN #16 stated that it the physician and get it is the resident was refusing to was asked why it was he TAR that it was on the 16 stated, "it should not be on if it is not being placed on hereactly policy titled "Care Plan" revealed, in part, the entation: "2. The care plan will: e. Identify the vices that are responsible for care and frequency of services	ie.			
	At an end of the p.m., ASM (adm	day meeting on 4/20/16 at 5:50 hinistrative staff member) #1, the ator; ASM #2, the director of	Э			
	assurance man manager; were findings. No fur prior to the end	ager) and ASM #4, the regional made aware of the above ther information was provided of the survey.				
	desinictration (	of the flu vaccination for the 201 u season in Resident #9's clinic	al i		- Housian sheat Pa	nge 117 of 12

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMEN' AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	f , ,		ONSTRUCTION		MPLETED
		495109	B, WING				/21/2016
	PROVIDER OR SUPPLIER URELS OF UNIVERSI		,	2420	EET ADDRESS, CITY, STATE, ZIP CODE D PEMBERTON RD HMOND, VA 23233		
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F 514	Continued From p	age 117	· F	514	<u>.</u>	<u>-</u> .	-
	11/21/14 with diag	admitted to the facility on incoses that included but were					
	not limited to neur	osyphillis,* major depressive		- 1			
-	disorder, altered r dementia.	mental status, chronic pain, and	:				
	set) was a quarter (assessment reference Resident #9 was understand others understood by othe Resident #9 was with transfers, dreambulation; exterence toileting, personal independent with						
	Resident #9's RF	nical record revealed that P (responsible party) had eive the flu vaccination annually as dated "1/26/14."	· ! ! ! !				
	Sheet) dated 4/2 initiated on 2/28/	ent #9's POS (Physician Order 1/16 revealed an active order 15 that documented the ccine: inject 0.5 ml (milliliters)					
	<del>i m (intramus</del> cul	ar <del>) once a year x 1 d</del> ese, march, if resident is not allergic	, 11 Fr				
	immunization red	f the clinical record revealed an cord. The immunization record offuenza Vaccination," was blank		 			
	Record) from 10	ARS (Medication Administration 1/1/15 to 4/21/16 revealed no e flu vaccination was given.			,		
I	(						

A BULLING CORRECTION  A95109  NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF UNIVERSITY PARK  THE LAURELS OF UNIVERSITY PARK  SUMMARY STATEMENT OF DEPLIENCES BY FLICT TO THE PROVIDER OR SUPPLIER  TAG  SUMMARY STATEMENT OF DEPLIENCES BY FLICT TO THE PROVIDED BY FLIL RESULATION FLOOR THE PROVIDER OR SUPPLIED BY FLIL RESULATION FLOOR THE APPROPRIATE DEPLIES OF CONTROL OR SUPPLIED BY FLICT TO THE APPROPRIATE DEPLIES OF CONTROL OR SUPPLIES BY FLICT TO THE APPROPRIATE DEPLIES OF CONTROL OR SUPPLIES BY FLICT THE SUPPLIES OF THE APPROPRIATE DEPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CONTROL OR SUPPLIES OF CON	CENTERS FOR MEDIO	CARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF UNIVERSITY PARK  (MA) ID PREFIX SUMMARY SYMEINT OF DEFICIENCIES (EACH DEPICIES/WINST BE PRECEDED BY FILL PREFIX TAG  (MA) ID PREFIX TAG  SUMMARY SYMEINT OF DEFICIENCIES (EACH DEPICIES/WINST BE PRECEDED BY FILL PREFIX TAG  (PA) ID PREFIX TAG  ON 4/20/16 at 5:30 p.m., an interview was conducted with LPN (Licensed practical nurse) #1, the unit manager. When asked who was responsible for tracking the fit vaccine steet that the unit managers were responsible. Site stated that when a resident receives the flu vaccination it is supposed to be written on the Resident's immunization form or MAR. When asked if she could find documentation regarding Resident #8 is flu vaccination in his clinical record, she stated, "No." She also stated that she could not find nursing notes addressing the flu vaccine. LPN #1 presented an immunization log that she uses for tracking vaccinations. Resident #9 was documented as receiving the flu vaccine. LPN #1 presented an immunization log that she uses for tracking vaccinations. Resident #9 was documented as receiving the flu vaccine. LPN #1 presented an immunization log that she uses for tracking vaccinations. Resident #9 was documented as receiving the flu vaccine to 11/11/15. When asked if the log was part of the resident's clinical record has been documented in Resident #9 clinical record has been documented in Resident #9 clinical record has been documented in Resident #9 clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's clinical record to the resident's cl			A. BUILDING	С		
THE LAURELS OF UNIVERSITY PARK  THE LAURELS OF UNIVERSITY PARK  THE LAURELS OF UNIVERSITY PARK  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAGS  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAGS  CONTINUED FROM INFORMATION)  F514  Continued From page 118  On 4/20/16 at 5:30 p.m., an interview was conducted with LPN (Licensed practical nurse) #1, the unit manager. When asked who was responsible for tracking the flu vaccines field that the unit managers were responsible. She stated that when a resident receives the flu vaccination it is supposed to be written on the Resident's immunization form or MAR. When asked if the could ind documentation regarding Resident #3's flu vaccination in his clinical record she stated, "No." She also stated that she could not find nursing notes addressing the flu vaccine. LPN #1 presented an immunization of yath at she uses for tracking vaccinations. Resident #9 was documented as receiving the flu vaccine on 111/11/15. When asked if the log was part of the resident's clinical record she stated, "This log is for my own personal use." LPN #1 stated that the flu vaccination should have been documented in Resident #65 clinical record she stated, "This log is for my own personal use." LPN #1 stated that the flu vaccination should have been documented in Resident #65 clinical record she stated, "This log is for my own personal use." LPN #1 stated that the flu vaccination should have been documented in Resident #65 clinical record she stated, "This log is for my own personal use." LPN #1 stated that the flu vaccination should have been documented in Resident #65 clinical record she stated, "This log is for my own personal use." LPN #1 stated that the flu vaccination should have been documented in Resident #65 colinical record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice.  Potter-Perry contains a quotation on page 477 regarding documentation as follows:		105100	R WING			
THE LAURELS OF UNIVERSITY PARK  THE LAURELS OF UNIVERSITY PARK  (PA) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (PACH CORRECTION ACTION SHOULD BE PREFIX TAG)  F514  Continued From page 118  On 4/20/16 at 5:30 p.m., an interview was conducted with LPN (Licensee practical nurse)  #1, the unit manager. When asked who was responsible for tracking the flu vaccine she stated that when a resident receives the flu vaccination it is supposed to be written on the Resident #3 flu vaccination in his clinical record, she stated, "No." She also stated that she could not find nursing notes addressing the flu vaccine. LPN #1 presented an immunization log that she uses for tracking vaccinations. Resident #9 was documented as receiving the flu vaccine on 11/1/11/5. When asked if the log was part of the resident's clinical record she stated. "This log is for my own personal use." LPN #1 stated that the flu vaccination should have been documented in Resident #9s clinical record.  On 4/20/16 at 6:04 p.m., administration was made aware of the above findings. No further information was presented prior to exit.  Potter-Perry contains a quotation on page 477 regarding documentation as follows:  "Documentation is anything-written or printed that it is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice.			STREET ADDRESS, CITY, STATE, ZIP	CODE		
Mail D   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   F514   Continued From page 118   F514     On 4/20/16 at 6:30 p.m., an interview was conducted with LPN (Licensed practical nurse)   #1, the unit manager. When asked who was responsible for tracking the flu veccine she stated that the unit managers were responsible. Site stated that when a resident receives the flu vaccination it is supposed to be written on the Resident's immunization form or MAR. When asked if site could find documentation regarding Resident #9's flu vaccination in his clinical record, she stated, "No." She also stated that she uses for tracking vaccination in the clinical record, she stated, "No." She also stated that she could not find nursing notes addressing the flu vaccine. LPN #1 presented an immunization log that she uses for tracking vaccinations. Resident #9 was documented as receiving the flu vaccine on 11/11/15. When asked if the log was part of the resident's clinical record she stated, "This log is for my own personal use." LPN #1 stated that the flu vaccination should have been documented in Resident #9's clinical record.  On 4/20/16 at 6:04 p.m., administration was made aware of the above findings. No further Information was presented prior to exit.  Potter-Perry contains a quotation on page 477 regarding documentation is arything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice.	NAME OF PROVIDER OR SUI	PLIER		į		
SUMMARY STATEMENT OF DEFICIENCIES  (REACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)  F 514  Continued From page 118  On 4/20/16 at 5:30 p.m., an interview was conducted with LPN (Licensed practical nurse) #1, the unit manager. When asked who was responsible for tracking the filu vaccine she stated that the unit managers were responsible. She stated that when a resident receives the flu vaccination it is supposed to be written on the Resident/s immunization form or MAR. When asked if she could find documentation regarding Resident #9's flu vaccination in his clinical record, she stated, "No." She also stated that she could not find nursing notes addressing the flu vaccine. LPN #1 presented an immunization log that she uses for tracking the flu vaccine on 11/11/15. When asked if the log was part of the resident's clinical record as tested, "This log is for my own personal use." LPN #1 stated that the flu vaccination should have been documented in Resident #9's clinical record.  On 4/20/16 at 6:04 p.m., administration was made aware of the above findings. No further information was presented prior to exit.  Potter-Perry contains a quotation on page 477 regarding documentation as follows:  "Documentation is anything written-or-printed that is relied on as record or proof for authorized persons. Documentation mist he accourate, when the proof is a vital aspect of nursing practice.	THE LAURELS OF UNIV	ERSITY PARK				
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that the unit managers were responsible. She stated that when a resident receives the flu vaccination it is supposed to be written on the Resident's immunization form or MAR. When asked if she could find documentation regarding Resident #9's flu vaccination in his clinical record, she stated, "No." She also stated that she could not find nursing notes addressing the flu vaccine. LPN #1 presented an immunization log that she uses for tracking vaccinations. Resident #9 was documented as receiving the flu vaccine on 11/11/15. When asked if the log was part of the resident's clinical record she stated, "This log is for my own personal use." LPN #1 stated that the flu vaccination should have been documented in Resident #9's clinical record.  On 4/20/16 at 6:04 p.m., administration was made aware of the above findings. No further information was presented prior to exit.  Potter-Perry contains a quotation on page 477 regarding documentation as follows: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice.	On 4/20/16 a conducted w	at 5:30 p.m., an interview was rith LPN (Licensed practical nurse) manager. When asked who was for tracking the flu vaccine she stat				
made aware of the above findings. No further information was presented prior to exit.  Potter-Perry contains a quotation on page 477 regarding documentation as follows: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice.  Nursing documentation must be accurate,	that the unit stated that vaccination Resident's in asked if she Resident #9 she stated, not find nurs LPN #1 pre uses for tradocumente 11/11/15. Versident's of for my own flu vaccinate Resident #	managers were responsible. She when a resident receives the flu it is supposed to be written on the mmunization form or MAR. When a could find documentation regardings of the waccination in his clinical recommon. She also stated that she counts and immunization log that she cking vaccinations. Resident #9 wacking vaccinations. Resident #9 wacking vaccinations. Resident #9 wacking vaccinations. Resident #9 wacking vaccinations. The sident #9 wacking vaccinations are stated, "This log personal use." LPN #1 stated that the clinical record.	g rd, d ne. e as e s the			
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is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice.	Potter-Per	ry contains a quotation on page 47				
is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice.	— Poolimen	tation is anything written or printed	that	<u> </u>		
persons. Documentation within a client medical record is a vital aspect of nursing practice.  Nursing documentation must be accurate,	in rolled or	as record of proof for authorized		;		
Number decline tation milst be accurate,	norcone	Documentation within a client inten-	Jai	1 :		
I the this anough to retrieve	Numerica de	acumentation must be accurate,				
comprehensive, and flexible enough to retrieve	comprehe	nsive, and flexible enough to retire	/e	4		
1		a maintain continuity of care, haci		:		
-ti-nt outcomes, and reflect current standards of	_tt_mt_oute	omes and reflect current standard	5 01	:		
nursing practice. Information in the client record provides a detailed account of the level of quality	nursing pr	actice. Information in the client fet a datailed account of the level of at	ality	<b>,</b>		
- farm delivered to clients - HICKIVE	provides a	slivered to clients. Effective		If continuation sheet Page 119 of 1		

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
STATEMENT OF AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				c
		495109	B. WING	REET ADDRESS, CITY, STATE, Z		/21/2016
1	ROVIDER OR SUPPLIER		24	20 PEMBERTON RD		
THE LAU	RELS OF UNIVERSI			ICHMOND, VA 23233 PROVIDER'S PLAN OF	CORRECTION	(X5) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	THE APPROPRIATE	DATE
			:			
F 514	Continued From p documentation en	sures continuity of care, saves	F 514			
	time, and minimiz	es the risks of errors (100am)		<u> </u>		
	the following infor	nurses need to communicate	1	· -		
	information about timely, effective n	clients accurately and in a	:			
	or spinal cord. It have had untreat information was https://www.nlm.	nih.gov/mediinepius/ericy/artick	S			
	3. The facility sta clinical record th to the hospital.	aff failed to document in the at Resident #25 was transferred	d .			
	2/19/16 with dia limited to: fracturinfection, ganground limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to the limited pressure to t	as admitted to the facility on gnoses that included but were race of the humerus, urinary tract ene of the left great toe, diabete sure, morbid obesity, depressio amputation, peripheral vascular	s, n,			
	The most recer assessment, a with an assess coded the reside BIMS (brief into that she was so daily decisions requiring exter dependent upon the fiber activities.)	nt MDS (minimum data set) Medicare 14 day assessment, ment reference date of 3/4/16, dent as scoring a seven on the erview for mental status) indicate everely impaired to make cognit. The resident was coded as asive assistance to being on one or more staff members for ties of daily living. In Section M as, the resident was coded as	or		If continuation s	heet Page 120 of 12
FORM C	MS-2567(02-99) Previous V		H82911	Facility-ID: VA0249		

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION		E SURVEY MPLETED
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILC	NG _			С
			B. WING			i	/21/2016
		495109	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	400	121/2010
NAME OF P	ROVIDER OR SUPPLIER			ł.	REET ADDRESS, CITT, STATE, ZIF GODE	-	
**** I P 1 A 1 1	RELS OF UNIVERSI	TV DARK					
IHE LAU	KELS OF DIMINEUS	II PARK		RI	CHMOND, VA 23233		
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F 514	Continued From p	age 120	; -F	514			
;	having a surgical v						
•			:				
	The list of dischar	ges for the past three months					-
1	was requested up	on entrance. Resident #25's	i	i			;
	name was listed w	ith a discharge date of 3/23/16.	- !-				
	It was documente	d that the resident was		:			•
	transferred to the	hospital.					
		did not rougal a note			1		
	Review of the clin	ical record did not reveal a note					i
	documenting whe	re or when the resident left the	!				
	facility. The last of	documented nurse's note was 10:49 a.m. There was nothing					1
	after that note.	10.49 a.m. There was nothing			* P. C. C. C. C. C. C. C. C. C. C. C. C. C.		į
	atter that hote.		-				
1	Paview of the nh	sician orders did not reveal any	. !		•		1
	documentation fo	r a transfer to the hospital.					:
	p.m. it was reque any documentation	day meeting on 4/20/16 at 6:18 sted for the facility to provide on regarding the resident's	· · · ·				
	transfer to the ho	spital.	:				•
	On 4/21/16 at 10	:55 a.m. an interview was					
	conducted with B	RN (registered nurse), the unit					:
	≕ manager #4. W	hen asked where the	1				
	<ul> <li>documentation w</li> </ul>	ras located, RN #4 stated, Sne	ŧ				
	went out to the d	octor's for an appointment and					1
	was sent directly	to the hospital by the surgeon					
ļ	for wound debrid	ement. When I went into the					
	computer to write	e a note, the resident had alread	ly i				
ļ	been discharged	out of the system." When aske	a į				i I
	what happens w	hen you can't document a	1				i
	nurse's note or a	anything in the chart related to	n		I .		1
	that resident, RN	#4 stated, "We revert to paper.	. !		:		
	When asked if s	he wrote a nurse's note, RN #4	to				i Ī
	stated, "I wrote a	a telephone order that she went					
	the hospital." Ag	ain, RN #4 was asked if she	3				
	wrote a nurse's	note on paper, RN #4 stated, "I nu <del>rse c</del> aring for her wrote a					
	aon't know it the	Tiurse caring for not wrote a					101.0

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	IPLE CONSTRUCTION		E SURVEY IPLETED
AND PLAN O	F CORRECTION	(DENTIFICATION DEL	A. BUILDII	VG		С
		495109	B. WING			/21/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2420 PEMBERTON RD RICHMOND, VA 23233	CODE	
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F 514	Continued From page	age 121	F 5	14		
	note. I did not." Wi	hen asked if there should be a	:			:
	nurse's note for a	resident sent to the hospital,		1		:
	RN #4 stated, "I th	ink so." RN #4 was for the	<u> </u>			-
	telephone order st	ne wrote. RN #4 presented a	1		The of combine off of the of	
ł	telephone order da	ated, 3/23/16 at 4:50 p.m. that		:		
	documented, Gue	est D/C'd (discharged) to (physician) office." When asked				
	nospital from MD	not in the clinical record, RN #4	1	ļ		
	Why this hole was	sitting on my desk." When	•			
	stated, I ve had it	ld have been in the clinical	i			
	record as the resid	dent was discharged on				
	3/23/16, RN #4 di	d not respond				
	3/23/10/10/10 mm di	d 1101, 00po., 1.				
	Documentation of	the 24 hour report was	1			
	presented on 4/21	1/16 at 11:15 a.m. from ASM		1		•
	(administrative sta	aff member) #3, the regional Q/	١	!		
	(quality assurance	e) Manager. The 24 hour repor	t			
	documented, "AB	T (antibiotics)/wound/URI				
	(unper respiratory	/ infection), MD appt				
	(appointment) tod	lay at 9:40 a.m. Pick up at 9:00	. !			
	a m " The second	l entry documented,				
	"ABT/Wound/URI	l out to MD appt - admitted to	i	:		
	hospital "			y.		į
	When asked if the	ere should be a nurse's note tha	at			
	the resident went	out to a doctor's appointment				
	and was directly a	admitted to the hospital, ASM #	3			
1	- stated "I would h	lave written one." When asked t	T i			
	the 24 hour repor	rt sheets were part of the clinica	ti :			<u> </u>
l	record, ASM #3 s	stated, "No."	1			
		and anyon of the charge				
	The administrato	r was made aware of the above	?			
	concern on 4/21/	76 at 12:15 p.m.	:			:
	!					:
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	!		i			
			:			
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