PRINTED: 06/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII	A. BOILBING		R-C	
	495109 B. WING		06/	01/2017			
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THELAND	DEL C OF LINIVEDCITY D	ADV		2	2420 PEMBERTON RD		
I THE LAUF	THE LAURELS OF UNIVERSITY PARK			F	RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS		{F 0	00}			
{F 157} SS=D	standard survey cond 4/13/17, was conduct Corrections are required. CFR Part 483 Federa Requirements. Unco identified within this redeficiencies are ident. The census in this 14 133 at the time of the consisted of 10 curre (Residents 101 through closed record reviews and 114). 483.10(g)(14) NOTIF (INJURY/DECLINE/R) (g)(14) Notification of (i) A facility must immonsult with the residence consistent with his or representative(s) when (A) An accident involves in injury and his physician intervention (B) A significant chan mental, or psychosocideterioration in health status in either life-throllinical complications.	rrected deficiencies are eport. Corrected ified on the CMS 2567-B. 5 certified bed facility was survey. The survey sample ent Resident reviews gh 109 and 112) and four se (Residents 110, 111, 113 Y OF CHANGES ROOM, ETC) Changes. rediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; ge in the resident's physical, sial status (that is, a n, mental, or psychosocial reatening conditions or); reatment significantly (that is,	{F 1:	57}			6/23/17
L ABORATORY	 	SUPPLIER REPRESENTATIVE'S SIGNATURE	1		TITLE		(X6) DATE

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.

Electronically Signed

06/16/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495109	B. WING		R-C 06/01/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	06/01/2017
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	ULD BE COMPLETION
{F 157}		erse consequences, or to	{F 15	7}	
	(D) A decision to tran resident from the faci §483.15(c)(1)(ii).	sfer or discharge the			
	(14)(i) of this section, all pertinent informati	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the			
	(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-				
	(A) A change in room as specified in §483.	or roommate assignment 10(e)(6); or			
		ent rights under Federal or ns as specified in paragraph			
	update the address (in phone number of the	record and periodically mailing and email) and resident representative(s).			
	Based on staff interv review, it was determ failed to notify the phy	iew and clinical record ined that the facility staff ysician of a need to alter 14 residents in the survey 06.		The Laurels of University Park wi have this submitted plan of correct stand as its allegation of complian date of alleged compliance is June 2017.	tion ice. Our
	physician aware med	d to make Resident #106's ications were unavailable to the resident on 5/29/17		Preparation and/or execution of the of correction does not constitute admission to, nor agreement with, the existence of or the scope and	either

A95109 B. WING C.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK (X4] ID PREFIX TAG (X4] ID REGULATORY OR LSC IDENTIFYING INFORMATION) (F 157) Continued From page 2 The findings include: Resident #106 was admitted to the facility on 3/27/17. Resident #106's diagnoses included but were not limited to: congestive heart failure, pneumonia and a rib fracture. Resident #106's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 4/23/17, coded the resident's cognition as moderately impaired. Review of Resident #106's clinical record revealed a physician's order summary signed by the physician on 6/1/17. The summary contained the following physician's orders: 4/28/17- Avapro (1) 300 mg (milligrams) - one tablet once per day for high blood pressure. 4/28/17-Toprol XL (2) - 25 mg- one half tablet STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233 STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233 STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233 PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CACH CORRECTION SHOULD BE CROSS-REFERENCED TO			405400	R WING				
THE LAURELS OF UNIVERSITY PARK (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 157) Continued From page 2 The findings include: Resident #106 was admitted to the facility on 3/27/17. Resident #106's diagnoses included but were not limited to: congestive heart failure, pneumonia and a rib fracture. Resident #106's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 4/23/17, coded the resident's cognition as moderately impaired. Review of Resident #106's clinical record revealed a physician's order summary signed by the physician on 6/1/17. The summary contained the following physician's orders: All residents currently in the facility have the potential to be affected. The DON/Designee will educate licensed nursing staff on notification to the MD in the event that treatment needs to be altered.			495109	B. WING _			5/01/2017	
CA4 ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DEFICIENCY DATE OF THE APPROPRIATE DEFICIENCY F 157 Continued From page 2 {F 157} Of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F Tag 157: F Tag 157: F Tag 157: F Tag 157: Provided the facility on some set of the provided page of the provided	NAME OF P	ROVIDER OR SUPPLIER				ODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 157) Continued From page 2 The findings include: Resident #106 was admitted to the facility on 3/27/17. Resident #106's diagnoses included but were not limited to: congestive heart failure, pneumonia and a rib fracture. Resident #106's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 4/23/17, coded the resident's cognition as moderately impaired. Review of Resident #106's clinical record revealed a physician's order summary signed by the physician on 6/1/17. The summary contained the following physician's orders: ### A 157	THE LAUI	RELS OF UNIVERSITY	PARK					
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE F 157 Continued From page 2 (F 157)					RICHMOND, VA 23233			
of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Frag 157: Tag 157: Resident #106's diagnoses included but were not limited to: congestive heart failure, pneumonia and a rib fracture. Resident #106's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 4/23/17, coded the resident's cognition as moderately impaired. Review of Resident #106's clinical record revealed a physician's order summary signed by the physician on 6/1/17. The summary contained the following physician's orders: All residents currently in the facility have the potential to be affected. The DON/Designee will educate licensed nursing staff on notification to the MD in the event that treatment needs to be altered.	PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPR		ON SHOULD BE HE APPROPRIATE	COMPLETION	
4/28/17- Montelukast (3) 10 mg- one tablet once per day for asthma. 4/28/17- Cymbalta (4) 60 mg- one capsule once per day for depression. Review of Resident #106's May 2017 MAR (medication administration record) revealed the Avapro was not administered to the resident on 5/29/17; Cymbalta was not administered to the resident on 5/30/17; Toprol XL was not administered to the resident on 5/30/17. The MAR notes documented, "PHARMACY TO DELIVER." The MAR notes failed to document Resident #106's physician was made aware the above medications were not administered to the medication reports with notes for all current residents for any medication that has been held due to medication availability. If treatment has been altered, the medical record will be audit for MD notification of treatment requiring alterations. Nursing administration will continue to monitor missed medications and notes 5 x a week for 4 weeks for any medication hat has been held due to medication availability. If treatment has been altered, the medical record will be audit for MD notification of treatment requiring alterations. Nursing administration will continue to monitior missed medication of treatment requiring alterations. Nursing administration of treatment requiring alterations. Additional education and notes 5 x a week for 4 weeks for any medication of treatment requiring alterations.	{F 157}	Resident #106 was 3/27/17. Resident is were not limited to: pneumonia and a rimost recent MDS (in Medicare assessmereference date) of 4 cognition as modern. Review of Resident revealed a physicia the physician on 6/2 the following physiciathe physician on 6/2 the following physiciathe physician on 6/2 the following physiciathe physician on 6/2 the following physician on 6/2 the following physician day for asthma. 4/28/17- Avapro IXL (once per day for high 4/28/17- Cymbaltather per day for depression deficiation administration administration of the following physician was made in the following physic	admitted to the facility on #106's diagnoses included but congestive heart failure, b fracture. Resident #106's minimum data set), a 30 day ent with an ARD (assessment #23/17, coded the resident's ately impaired. #106's clinical record n's order summary signed by 1/17. The summary contained cian's orders: #300 mg (milligrams) - one for high blood pressure. #2) - 25 mg- one half tablet gh blood pressure. #3100 mg one capsule once ion. #106's May 2017 MAR stration record) revealed the ministered to the resident on was not administered to the and 5/30/17; Montelukast ed to Resident #106 on was not administered to the . The MAR notes RMACY TO DELIVER." The odocument Resident #106's e aware the above	{F 15	of any of the cited deficience conclusions set forth in the deficiencies. This plan is prexecuted to ensure continu with regulatory requirement F Tag 157: Resident # 106- No negative occurred as a result of this All residents currently in the the potential to be affected. The DON/Designee will edunursing staff on notification the event that treatment negaltered. Nursing administration will a medication reports with not current residents for any me has been held due to medicavailability. If treatment has the medical record will be a notification of treatment regulaterations. Nursing administration will monitor missed medications a week for 4 weeks for any treatment and documentation of the daily clinic Additional education and/or will be provided as indicate will be reported by the DON	statement of repared and/or ing compliance is. re outcome practice. re facility have cucate licensed to the MD in eds to be audit missed es for all edication that cation is been altered, audit for MD juiring continue to s and notes 5 x altered on of MD cal meeting . It counseling it counseling it.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	1 00/01/2017	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION
{F 157}	reference date of 4/4/s specific information remedications. The nurse who was rethe above medication interview. On 6/1/17 at 11:25 a. conducted with LPN (LPN #1 was asked we medications are not at LPN #1 stated the nurse to obtain the medications when the conducted with the medications when the conducted with LPN (LPN #1 stated the nurse to obtain the medications when the conducted with the medications when the conducted with the medications when the conducted with the conducted wi	prehensive care plan with a draw failed to document regarding the above responsible for administering is was not available for regarding the about the second practical nurse) #1. That should be done if available for administration, and interview was responsible for administration, and the physician will tell the redications at that time or the responsible to the regarding was requested. On 6/1/17 dministrative staff member regarding was requested. On 6/1/17 dministrative staff member regarding was requested the facility did red policy. The was presented prior to exit. The treat high blood pressure obtained from the website: his gov/dailymed/archives/fd reid=18004	{F 157	Continued compliance will be monitor through the facility squality assurar program. Additional education and monitoring will be initiated for any identified concerns. Completion date: June 23, 2017		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
			7 55.25			R-C	
		495109	B. WING _		06	/01/2017	
	IDER OR SUPPLIER S OF UNIVERSITY PA	ARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
(i) ind be recret (ii) ex an ott pla	formation was obtaites://dailymed.nlm.r?setid=ccbbf0d6-ef6dd-9e7b-e3d293062) Cymbalta is used formation was obtaites://dailymed.nlm.r?setid=2f7d4d67-103.10(c)(2)(i-ii,iv,v)(3ARTICIPATE PLANN 103.10)(2) The right to participate included in the plaquest meetings and outlines of the person of the right to participate included in the plaquest meetings and outlines of the person of the person of the right to participate included in the plaquest meetings and outlines of the person of the right to participate and of the person of the right to participate and of the person of the right to participate of the person of the right to participate of the person of the person of the right to receive the person of the plan of the plan of the right to see the plan of the right to see the person of the right to see the person of the right to see the person of the plan of the plan of the right to see the person of the right to see the person of the plan of th	ra2-4e4c-10b7- sed to treat asthma. This ned from the website: hih.gov/dailymed/drugInfo.cf d9- 2609 It to treat depression. This ned from the website: hih.gov/dailymed/drugInfo.cf dc1-4bf4-a7f2-c185fbad64ba d3),483.21(b)(2) RIGHT TO NING CARE-REVISE CP ticipate in the development of his or her person-centered of but not limited to: the attention of the planning process, dentify individuals or roles to the right to request on-centered plan of care. The attention of care, and any to the effectiveness of the of the services and/or items	{F 28			6/23/17	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495109	B. WING				R-C 06/01/2017	
	ROVIDER OR SUPPLIER	ARK		STREET ADDRESS, 2420 PEMBERTON RICHMOND, VA		1 00/	01/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 280}	right to participate in I shall support the resident shall support the resident planning process must (ii) Facilitate the inclust resident representative (iii) Include an assess strengths and needs. (iii) Incorporate the recultural preferences in 483.21 (b) Comprehensive C (2) A comprehensive C (2) A comprehensive as (ii) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not limit (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident.	Il inform the resident of the his or her treatment and dent in this right. The st sion of the resident and/or ve. ment of the resident's esident's personal and no developing goals of care. Fare Plans care plan must be- or days after completion of essessment. Iterdisciplinary team, that sited to or visician. Iter with responsibility for the	{F 2	80}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495109	B. WING		R-C 06/01/2017
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2011
THE LANG	DELO OF HAINFEDOITY D	ADIC		2420 PEMBERTON RD	
THE LAURELS OF UNIVERSITY PARK		ARK		RICHMOND, VA 23233	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECT	
· · · — · · · · · · · · · · · · · · · ·		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	
{F 280}	Continued From pag	e 6	{F 280	D}	
		participation of the resident oresentative is determined e development of the			
		e staff or professionals in ined by the resident's needs ne resident.			
	team after each asse comprehensive and dassessments.				
	by:	Γ is not met as evidenced			
		on, staff interview and clinical determined that the facility		Ftag 280	
	staff failed to review			Resident # 106- The care plan has	s been
		plan for two of 14 residents		revised and updated. No negative	
		, Residents #106 and #109.		outcome occurred as a result of th practice.	IS
	,	iled to revise Resident		Danisland #400. The same relations	h
	healed.	eflect a pressure injury had		Resident #109- The care plan has revised and updated. No negative outcome occurred as a result of th	
	2. The facility staff fa #109's care plan rega	iled to revise Resident arding the resident's		practice.	
	non-compliance with	a bed alarm.		Residents with Pressure Ulcers or Non-compliance related to fall	
	The findings include:			interventions have the potential to affected.	be
	1. The facility staff fa	iled to revise Resident			
	· •	eflect a pressure injury had		The DON/designee will educate no administration, MDS staff, and lice nursing staff on revising the care p	nsed
	3/27/17. Resident #7 were not limited to: c	idmitted to the facility on 106's diagnoses included but ongestive heart failure, fracture. Resident #106's		when wounds have resolved, and documenting non- compliance with devices.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDING	<u> </u>		R-C	
		495109	B. WING		06/01/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	! E	00/01/2017	
				2420 PEMBERTON RD			
THE LAUF	RELS OF UNIVERSITY PA	ARK		RICHMOND, VA 23233			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE	
{F 280}	{F 280} Continued From page 7		{F 28	0}			
	most recent MDS (mi	nimum data set), a 30 day		Nursing administration will au	dit care		
	Medicare assessmen	t with an ARD (assessment		plans for current residents wit	h pressure		
	reference date) of 4/2	23/17, coded the resident's		ulcers and residents with reso	olved		
		ely impaired. Section M		pressure ulcers for revisions r	needed. An		
	documented Residen	t #106 had one unstageable		audit will also be conducted for	or all		
	pressure injury (1).			residents who have orders for			
				alarms for revisions needed. A			
	Review of a wound care specialist evaluation dated 5/5/17 revealed an unstageable pressure injury on Resident #106's upper back was resolved (healed) on 5/5/17. A weekly skin assessment dated 5/31/17 documented Resident			education and/or counseling v			
				provided as indicated. Conce			
				reported by the DON to the quassurance committee.	uanty		
				assurance committee.			
	#106's skin was intac						
		plan with a reference date of					
		At Increased risk for skin		Nursing administration will rev	iew new		
	break down R/T (rela	ted to) Occasional urinary		orders and nursing notes for s			
	incontinence, Actual i	mpaired skin integrity:		alarms, and pressure ulcer tre	eatments 5 x		
	pressure injury, site: I	Back"		week for 4 weeks. Additional			
				and/or counseling will be prov			
	On 6/1/17 at 11:25 a.			indicated. Concerns will be re			
		licensed practical nurse) #1.		the DON to the quality assura	nce		
		esident #106's pressure		committee.			
		1/17. LPN #1 also confirmed					
	· ·	an documented Resident ve a pressure injury. LPN		Continued compliance will be	monitored		
		should be updated when a		through the facility s quality a			
		led and the nurse who		program. Additional education			
	ı · · · · ·	ment orders should update		monitoring will be initiated for			
	the care plan.			identified concerns.	,		
		m., ASM (administrative		Completion date:			
	' '	administrator) was made		June 23, 2017			
		ndings. A policy regarding					
		ested. On 6/1/17 at 1:30					
	l • • • • • • • • • • • • • • • • • • •	ative staff member) #2 (the					
		ated the facility did not have					
	the requested policy.						
	No further information	n was presented prior to exit.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· /	(X3) DATE SURVEY COMPLETED	
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R		STREET ADDRESS, CITY, STATE, ZIP COI 2420 PEMBERTON RD RICHMOND, VA 23233		06/01/2017	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
ury: y is localized damage to the skin soft tissue usually over a bony elated to a medical or other ry can present as intact skin or and may be painful. The injury elit of intense and/or prolonged sure in combination with shear. I soft tissue for pressure and be affected by microclimate, on, co-morbidities and condition essure Injury: Obscured in and tissue loss sin and tissue loss in which the damage within the ulcer cannot cause it is obscured by slough or in or eschar is removed, a Stage ssure injury will be revealed. e. dry, adherent, intact without tuance) on the heel or ischemic de softened or removed" This obtained from the website: p.org/resources/educational-and- s/npuap-pressure-injury-stages/? optQCFQ-BaQodwvAMJg aff failed to revise Resident ir regarding non-compliance with a vas readmitted to the facility on int #109's diagnoses included but to: high blood pressure, skin	{F 280				
THE PROPERTY OF THE SELECTION OF THE SEL	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL	A BUILDING 495109 B. WING B. WING ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) In page 8 If page 8 (F 280) If page 8 (F 280) If page 8 (F 280) If page 8 If page 9 I	A BUILDING 495109 B. WING STREET ADDRESS, CITY, STATE, ZIP COL 2420 PEMBERTON RD RICHMOND, VA 23233 BY OR LSC IDENTIFYING INFORMATION) PAGENT (ACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) In page 8 (F 280) Jury: ry is localized damage to the skin soft tissue usually over a bony elated to a medical or other rury can present as intact skin or not may be painful. The injury ult of intense and/or prolonged ssure in combination with shear. If soft tissue for pressure and be affected by microclimate, ion, co-morbidities and condition a essure Injury: Obscured in and tissue loss kin and tissue loss in which the damage within the ulcer cannot recause it is obscured by slough or the or eschar is removed, a Stage essure injury will be revealed. e.e. dry, adherent, intact without attuance) on the heel or ischemic be softened or removed" This obtained from the website: up.org/resources/educational-and- es/npuap-pressure-injury-stages/? optQCFQ-BaQodwvAMJg aff failed to revise Resident in regarding non-compliance with a was readmitted to the facility on ent #109's diagnoses included but to: high blood pressure, skin eizure disorder. Resident #109's S (minimum data set), an annual	A BUILDING 495109 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTOR RD RICHMOND, VA 23233 ID PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) In page 8 (F 280) Ipury: Ty is localized damage to the skin soft tissue usually over a bony elated to a medical or other tury can present as intact skin or not may be painful. The injury att of intense and/or prolonged soure in combination with shear. For this sessure injury: Sisue is an advised by slough or hor eschar is removed, a Stage sesure injury will be revealed. Be affected by microclimate, inno resonance is removed, a Stage sesure injury will be revealed. Be dry, adherent, intact without tutuance) on the heel or ischemic be softened or removed" This obtained from the website: The progressure-seducational-and-si/npuap-pressure-injury-stages/? app(QCFQ-BaQodwvAMJg) aff failed to revise Resident in regarding non-compliance with a was readmitted to the facility on ant #109's diagnoses included but to: high blood pressure, skin eizure disorder. Resident #109's S (minimum data set), an annual	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
495109 B. WING					I-C (01/2017		
	ROVIDER OR SUPPLIER	ARK		2420	EET ADDRESS, CITY, STATE, ZIP CODE PEMBERTON RD HMOND, VA 23233	1 00/	01/2017
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 280}	date) of 3/6/17 coded cognitively intact. Review of Resident # revealed a physician the physician on 5/26 documented an order alarm. Observations of Resident # 3:10 p.r a.m. During both observed lying in disconnected. Resident #109's compreference date of 5/3: At risk for fall related placement and function plan failed to document non-compliant with the Con 6/1/17 at 11:25 a. conducted with LPN (LPN #1 stated she had Resident #109 discort had seen him "messes stated she had heard Resident #109 had dipast. When asked if non-compliance should stated, "Yes." On 6/1/17 at 12:30 p. conducted with LPN # Resident #109's non-compliance should stated with LPN # Resident #109's non-conducted with LPN # Resident #109's non-conducted with LPN # Resident #109's non-compliance should residen	the resident as being 109's clinical record order summary signed by 17. The summary dated 5/19/17 for a bed dent #109 were conducted m. and on 6/1/17 at 7:55 servations, Resident #109 bed and the bed alarm was prehensive care plan with a 1/17 documented, "FALLS: injuryBed alarm check on every shift" The care ent Resident #109 was be bed alarm. m., an interview was (licensed practical nurse) #1. ad never personally seen nect the bed alarm but she with" the alarm. LPN #1 from other staff that seconnected the alarm in the the resident's ald be documented, LPN #1 m. another interview was #1. LPN #1 was asked if compliance with the bed umented on the resident's	{F 2	80}			

PRINTED: 06/20/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495109	B. WING	B. WING		R-C 06/01/2017	
	ROVIDER OR SUPPLIER	ARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 280}	staff member) #1 (the aware of the above fil care plans was reque p.m., ASM (administra	e 10 m., ASM (administrative e administrator) was made endings. A policy regarding sted. On 6/1/17 at 1:30 ative staff member) #2 (the ated the facility did not have	{F 2	280}			
{F 309} SS=D	483.24, 483.25(k)(l) FFOR HIGHEST WELI 483.24 Quality of life Quality of life is a funcapplies to all care and residents. Each residents. Each residents. Each residents to attain or in practicable physical, well-being, consistent comprehensive assess 483.25 Quality of care Quality of care is a funcapplies to all treatment facility residents. Bas assessment of a resident residents receive accordance with profession and the resident plan, and the resident provided to residents consistent with professions and the residents consistent with professions.	damental principle that discretices provided to facility dent must receive and the he necessary care and maintain the highest mental, and psychosocial to with the resident's esment and plan of care.	{F 3	009}		6/23/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X:	(X3) DATE SURVEY COMPLETED		
		495109	B. WING _			R-C 06/01/2017	
	ROVIDER OR SUPPLIER	ARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	I	00/01/2017	
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 309}	services, consistent to of practice, the comp care plan, and the repreferences. This REQUIREMENT by: Based on staff interview, it was determ failed to provide services and well-being for survey sample, Resident #105 was time of his facility and facility failed to devel services for Resident provided by the facility The findings include: 1. The facility staff facility failed to devel services for Resident provided by the facility The findings include: 1. The facility staff facilit	ity must ensure that e dialysis receive such with professional standards rehensive person-centered sidents' goals and I is not met as evidenced riew and clinical record sined that the facility staff ices to maintain the highest or two of 14 residents in the dents #106 and #105. Alled to administer physician ries to Resident #106 on Is admitted to hospice at the mission on 3/29/17. The op a care plan for hospice at the care that the hospice provider. Alled to administer physician ries to Resident #106 on Identify and the hospice provider.	{F 30	Ftag 309 Resident #106- No negative out occurred as a result of this pract medications are currently availal facility Resident #105- The care plan have revised to reflect hospice service hospice provider has provided the plan to the medical record. No noutcome occurred as a result of practice. DON or designee will educate not administration and licensed nurse on the procedure of obtaining methat are not currently in the medicant. The stat box medication list reviewed and made available to nursing staff at all times. In additing they will be educated on notification nursing administration and/or NH assistance can be provided to elemedications are available.	ice. All ble at the as been es. The neir care egative this ursing sing staff edications it will be the tion to this tion to HA so	S	
	most recent MDS (m Medicare assessmer	fracture. Resident #106's inimum data set), a 30 day at with an ARD (assessment 23/17, coded the resident's		DON or designee will educate no administration, MDS and license staff on putting a care plan in pla	ed nursing	3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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{F 309}	revealed a physicial the physician on 6/ the following physician on 6/ the following physician on 6/ the following physician development of the following physician devices and for asthma 4/28/17- Monteluka per day for depressible for depressible for the following physician devices document of the following physician development	ately impaired. #106's clinical record n's order summary signed by 1/17. The summary contained cian's orders: 1) - 25 mg- one half tablet gh blood pressure. st (2) 10 mg- one tablet once (3) 60 mg- one capsule once	{F 3(those residents receiving h services. Nursing administration or d audit medication carts to as medications are available a Nursing administration will plans for all current resident hospice services. Correction made as appropriate and with the DON. Nursing administration will monitor through the review medications and notes 5 x weeks for any altered treated documentation of MD notification daily clinical meeting. Nursiadministration will review not hospice weekly x 4 week care plans. Additional educounseling will be provided Concerns will be reported to the quality assurance committed.	lesignee will ssure that all and in place. review care nts receiving ons will be will be reported continue to of missed week for 4 ment and ication in the sing lew admission in the sing lew admission cation and/old as indicated by the DON in the state of the sing lew admission and/old as indicated by the DON in the sing lew admission and/old as indicated by the DON in the state of the sing lew admission and/old as indicated by the DON in the state of the s	ed ense ee er d.		
	conducted with LPI LPN #1 was asked for ensuring medica administration. LPI reorder medication stated if medication administration then facility STAT (Imme various medications	a.m., an interview was N (licensed practical nurse) #1. What was the facility process ations are available for N #1 stated nurses should s when they run low. LPN #1 as are not available for nurses should check the diate) box (a box containing s) to see if it contains the not, then nurses should call		Continued compliance will through the facility squality program. Additional educate monitoring will be initiated to identified concerns. Completion date: June 23, 2017	ty assurance tion and			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		OATE SURVEY OMPLETED
		495109	B. WING _			R-C 06/01/2017
	ROVIDER OR SUPPLIER	PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	·	00/01/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
{F 309}	STAT (immediately). On 6/1/17 at 12:45 p staff member) #1 (th aware of the above f medication administre 6/1/17 at 1:30 p.m., amember) #2 (the dire facility did not have to time, ASM #2 was amedications were not #106 on 5/30/17 if the facility on 5/29/17. At the facility on 5/29/17 if the facility on 5/29/17. At the facility on 5/29/17 if the facility on 5/29/17 if the facility on 5/29/17. At the facility on 5/29/17 if th	are the medications sent a.m., ASM (administrative e administrator) was made findings. A policy regarding ration was requested. On ASM (administrative staff ector of nursing) stated the the requested policy. At this sked why the above at administered to Resident the medications arrived at the ASM #2 stated she was trying medications were not #2 stated medications are the medication cart as soon arrive. In was presented prior to exit. In d to treat high blood mation was obtained from the anih.gov/dailymed/drugInfo.cf d7a2-4e4c-10b7- ased to treat asthma. This ained from the website: anih.gov/dailymed/drugInfo.cf fd9-	{F 30	09}		
	2. Resident #105 wa	0c1-4bf4-a7f2-c185fbad64ba s admitted to hospice at the mission on 3/29/17. The				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	1 '	DATE SURVEY COMPLETED
		495109	B. WING			R-C 06/01/2017
	ROVIDER OR SUPPLIER	11.11		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		00/01/2017
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 309}	services for Reside provided by the face Resident #105 was 3/29/17 with diagnot to: metastatic prosidisease, and glauce MDS (minimum datassessment with the of 3/29/17, he was cognitively impaired. He was coded as reduring the look bace. A review of Resider revealed the following the physician on of [name of hospice of the following the physician of the provided for the provided A review of Resider revealed the following the physician of the physician of the physician of the physician of the provided for the physician of the phy	elop a care plan for hospice int #105 to coordinate the care ility and the hospice provider. admitted to the facility on uses including, but not limited tate cancer, Alzheimer's oma. On the most recent a set), an admission e assessment reference date coded as being severely for making daily decisions. Ecciving hospice services in price prices in the price of the pri	{F 30	09}		
	#105's comprehens	ive care plan for information are, LPN #1 reviewed the d: "I don't see anything."				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY
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		495109	B. WING			06/	01/2017
	ROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	ARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		
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{F 309}	hospice, LPN #1 state hospice care plan." On 6/1/17 at 10:10 a. staff member) #1, the informed of these constated that the facility related to the coordinate services/hospice care	ility should develop a coordinate the care with ed: "Yes, there should be a m., ASM (administrative administrator, was ocerns. At this time, she does not have a policy ation of hospice	{F 3	309			
{F 371} SS=E	483.60(i)(1)-(3) FOOD STORE/PREPARE/SI (i)(1) - Procure food fr considered satisfactor authorities. (i) This may include for from local producers, and local laws or regular (ii) This provision doe facilities from using progradens, subject to consider growing and food (iii) This provision doe from consuming foods (i)(2) - Store, prepare accordance with profeservice safety. (i)(3) Have a policy resulting the store of th	O PROCURE, ERVE - SANITARY From sources approved or Try by federal, state or local Frod items obtained directly Subject to applicable State Froduce grown in facility Froduce with applicable	{F 3	371			6/23/17

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495109	B. WING		R-C
NAME OF PI	ROVIDER OR SUPPLIER	400100		STREET ADDRESS, CITY, STATE, ZIP CODE	06/01/2017
				2420 PEMBERTON RD	
THE LAUF	RELS OF UNIVERSITY PA	ARK		RICHMOND, VA 23233	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
{F 371}	Continued From page	e 16	{F 371	}	
	handling, and consun This REQUIREMENT by:	is not met as evidenced			
	Based on observation, staff interview and facility document review, it was determined that the facility staff failed to prepare and serve food in a			Ptag 371 No negative outcome occurred as a re	esult
	sanitary manner.			of this practice.	
	guards in the kitchen	nbers failed to wear beard during an observation on staff failed to wash, rinse,		The employees who require beard gu have them in place when in the kitche	
	and sanitize trays and on 5/21/17.	d plate covers between uses		The trays and lids were all washed, rinsed, and sanitized on the same day the deficient practice was identified.	y that
	The findings include:			·	
	staff on 5/31/17 at 11 observation, OSM (ot	was made of the kitchen :10 a.m. At the time of this ther staff member) #2, a		All residents have the potential to be affected by this practice.	
	food preparation area	erved moving around in the in the kitchen. He had a of wearing a beard guard.		The acting dietary manager or design will educate dietary staff on wearing b guards and who qualifies to be wearir	eard
	OSM #2, a dietary aid	de, was observed moving n into the dry storage room,		them. The acting dietary manager or designee will also educate the dietary	
	He had partial beard, beard guard. During the cook, informed th	s into the walk-in refrigerator. and was not wearing a this observation, OSM #1, e surveyor that the facility's		department on the appropriate proced for washing, rinsing, and sanitizing dis	shes.
		r was broken, and that all ses were being washed by		The acting Dietary manager or design will conduct observations of beard gua in place 2 x day x 1 week. The acting dietary manager or designee will conduct the conduction of t	ards
	11:35 a.m., OSM #2 \	al observation, on 5/31/17 at was interviewed. When hat on his head in the		observations of dishes being washed the 3 compartment sink daily x 1 weel	in
	the way." When aske	ed: "To keep my hair out of ed if there were any other e wearing to protect hair		NHA and dietary manager will continumonitor sanitation through weekly kitorounds x 4 weeks Additional education	chen

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		495109	B. WING _			06/	01/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THEIAII	RELS OF UNIVERSITY PA	A D K		2	420 PEMBERTON RD		
IIIL LAGI	CEEO OF ORIVERON 17	- TANK		R	ICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 371}	Continued From page	e 17	{F 3	71}			
	from falling in the foo	d, he stated: "I don't think e should have been wearing # 2 stated: "Oh yeah. I			and/or counseling will be provided as indicated. Concerns will be reported to quality assurance committee monthly uresolved.		
	When asked if he sho beard guard, OSM #3 always around the for somewhere else." W located in the kitchen observation, OSM #3 is that my beard hair	SM #3 was interviewed. Suld have been wearing a B stated: "No. I'm not od. Most of the time I am then asked if he had been during the time of the stated: "Yes. But the rule is not long enough. I'm not to be for me to wear one, but long enough."			Dietary manager will continue to monitobeard guards being in place on staff in kitchen weekly x 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported to the quality assurance committee monthly until resolved.	the	
	the kitchen. At this til was observed rolling trays from the area whad been unloaded to the tray line. OSM #4 the cart, swiped each and placed each tray beginning of the tray putting the eight trays ready for use, he stat OSM #1, the cook wa #1 stated: "If I have twhat I'm going to do. there (pointing to the dishes had been unlocart of trays back to it was asked if the trays beginning of the tray stated: "Yes. I wiped then asked if the tray beginning of the tray beginning of the tray	m., the surveyor returned to me, OSM #4, a dietary aide, a cart stacked high with here dirty dishes from lunch to the area at the beginning of a picked up eight trays from a tray lightly with a dish towel, on a tray holder at the line. When asked if he was a in a place where they were red: "Yes." At this time, alked over to ASM #4. OSM to tell you again, I don't know Take those trays back over area where the dirty lunch readed). OSM #4 rolled the test original position. OSM #4 is he had just placed at the line were clean. OSM #4 them off." OSM #1 was so OSM #4 had placed on the line were clean. OSM #1 them last night. And we			Continued compliance will be monitore thought the facility squality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: June 23, 2017		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRU	JCTION	(X3) DATE COMF	SURVEY
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NAME OF P	ROVIDER OR SUPPLIER	495109	B. WING	STREET ADD	DRESS, CITY, STATE, ZIP CODE	06/	01/2017
THE LAU	RELS OF UNIVERSITY PA	ARK		2420 PEMBERTON RD RICHMOND, VA 23233			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE
{F 371}	washed them after br wash them after lunci in question were cleated told him. But he does the day was "all back dishwasher and abses She stated the trays abeen washed that me and lunch in the two asked if all of these it rinsed and sanitized, what we could. I thou do it." OSM #1 return preparing dinner and trays placed at the best of the stated: "Yes." He stated: "Yes."	reakfast. But we did not h." When asked if the trays in, OSM #1 stated: "No. I is not listen." OSM #1 stated wards" due to the broken ence of the dietary manager. and the plate covers had orning "between breakfast compartment sink." When ems had been washed, OSM #1 stated: "No. I did ught that is how we should ned to her activities of did not address the dirty eginning of the tray line. m., the surveyor returned to (administrative staff hinistrator. OSM #2 was ed the trays between hat morning. OSM #2 ated the trays and plate in the two compartment sink stated trays were placed on and plate covers were. He stated one side of the loap and bleach in the water, the sink contained bleach hen asked to demonstrate washed, rinsed and ated: "We washed them in them under the water. We ome with a towel." When anys or plate tops had been see, and prior to being stored	{F 3	71}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495109	B. WING			R-C 06/01/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		06/01/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 371}	revealed, in part, the shall be worn by all diduty to cover all hair. acceptable as hair reserstraintThis applies kitchen including main administration." A review of the facility Washing" revealed, in "Manually washed poutensils shall be adequashed pots, pans ar washed to ensure the sanitized using a threshall be allowed to air board/rack/cartPan(dish towel." A review of the manual dishwashing liquid us reveal information relaserving ware. No further information 483.45(a)(b)(1) PHAFACCURATE PROCEITAGO (a) Procedures. A fact pharmaceutical service that assure the accurate dispensing, and administration in the serving ware.	r policy "Hair Restraints" following: "Hair restraints etary employees while on The following are straintsbeard to to all staff entering the intenance and r policy "Manual Ware in part, the following: ts, pans and cooking quately sanitizedManually ind cooking utensils shall be it all items are adequately e compartment sinkPan(s) r-dry on sanitized drain (s) shall not be wiped with a facturer's instructions for the ed by the faculty failed to atted to sanitizing dish and was provided prior to exit. RMACEUTICAL SVC - DURES, RPH cility must provide these (including procedures atte acquiring, receiving, inistering of all drugs and the needs of each resident.	{F 3			6/23/17	
	(b) Service Consultati	ori. The facility must					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	(X3) DATE SURVEY COMPLETED	
		495109	B. WING _			R-C 6/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP COI	•	0/01/2011	
THE ! ALIE		/ DA DI/		2420 PEMBERTON RD			
THE LAUF	RELS OF UNIVERSITY	PARK		RICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 425	Continued From pa	age 20	F 4	25			
	employ or obtain the pharmacist who	ne services of a licensed					
	provision of pharm This REQUIREME	litation on all aspects of the acy services in the facility; NT is not met as evidenced					
	review, it was dete failed to ensure me administration as o	erview and clinical record rmined that the facility staff edications were available for ordered by the physician for one he survey sample, Resident		Resident #106- No negative occurred as a result of this p Medications are available in	ractice. the facility.		
	ordered by the phy	led to ensure medications visician were available for desident #106 on 5/29/17.		All residents have the potent affected. DON or designee will educat administration and licensed ron the procedure of obtaining	te nursing nursing staff g medications		
	3/27/17. Resident were not limited to pneumonia and a i most recent MDS (Medicare assessm	s admitted to the facility on #106's diagnoses included but congestive heart failure, ib fracture. Resident #106's minimum data set), a 30 day lent with an ARD (assessment 4/23/17, coded the resident's rately impaired.		that are not currently in the n cart. The stat box medication reviewed and made available nursing staff at all times. In a they will be educated on noti nursing administration and/o assistance can be provided t medications are available.	n list will be e to the addition to this ification to or NHA so		
	revealed a physicia	at #106's clinical record an's order summary signed by 11/17. The summary contained cian's orders:		Nursing administration or de- audit medication carts to ass medications are available an Corrections will be made as and will be reported to the De-	sure that all nd in place. appropriate		
	tablet once per day) 300 mg (milligrams) - one y for high blood pressure. (2) 60 mg- one capsule once sion.		Nursing administration will commonitor through the review in medications and notes 5 x a weeks for any altered treatm documentation of MD notifical	nissed week for 4 nent and		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		TE SURVEY MPLETED
		495109	B. WING _			R-C
NAME OF PR	ROVIDER OR SUPPLIER	400100	1	STREET ADDRESS, CITY, STATE,		6/01/2017
				2420 PEMBERTON RD		
THE LAUF	RELS OF UNIVERSITY PA	ARK	RICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 425	Continued From page	e 21	 F4	25		
	Review of Resident # (medication administration Avapro and Cymbaltathe resident on 5/29/1/20 documented, "PHARI were no nurses' notes the facility STAT (Immavapro and Cymbaltafacility STAT boxes (Emedications).	106's May 2017 MAR ation record) revealed were not administered to		daily clinical meeting education and/or couns provided as indicated. reported by the DON to assurance committee. Continued compliance through the facility s q program. Additional ed monitoring will be initia	seling will be Concerns will be the quality will be monitored quality assurance ucation and	
		s was not available for		identified concerns.	ted for any	
	LPN #1 was asked w for ensuring medication administration. LPN a reorder medications wastated if medications administration then not facility STAT box to so medications and if not the pharmacy and ha STAT (immediately). takes the pharmacy "medications. LPN #1 pharmacy more than STAT medications. On 6/1/17 at 12:45 p. staff member) #1 (the	hat was the facility process ons are available for #1 stated nurses should when they run low. LPN #1 are not available for urses should check the ee if it contains the t, then nurses should call we the medications sent LPN #1 stated sometimes it a little while" to deliver STAT stated it should not take the two or three hours to deliver		Completion date: June 23, 2017		
	aware of the above fit medication administra 6/1/17 at 1:30 p.m., A	ation was requested. On SM (administrative staff ctor of nursing) stated the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495109	B. WING		R-C 06/01/2017
	ROVIDER OR SUPPLIER	ARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	00/01/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 465 SS=D	(1) Avapro is used to This information was https://dailymed.nlm.aDrugInfo.cfm?archi (2) Cymbalta is use information was obtainttps://dailymed.nlm.m?setid=2f7d4d67-1483.90(i)(5) SAFE/FUNCTIONALE ENVIRON (i) Other Environment The facility must provisanitary, and comfor residents, staff and to (5) Establish policies applicable Federal, Seegulations, regarding and comfor regulations, regarding the staff and to the component of the	he requested policy. In was presented prior to exit. In otreat high blood pressure. In obtained from the website: Inih.gov/dailymed/archives/fd Iveid=18004 Ind to treat depression. This Inined from the website: Inih.gov/dailymed/drugInfo.cf Inih.gov/dailymed/archives/fd Inih.gov/dailymed/archives/fd Inih.gov/dailymed/archives/fd Inih.gov/dailymed/archives/fd Inih.gov/dailymed/archives/fd Inih.gov/dailymed/drugInfo.cf Ini	F 42	5	6/23/17
	non-smoking resider This REQUIREMEN' by: Based on observation document review, it was staff failed to store has manner for one of five Jefferson Unit. Facility staff failed to Neutral (one-step dis	T is not met as evidenced on, staff interview, and facility was determined that facility azardous chemicals in a safe		Ftag 465 The shower room cabinet has been locked. No negative outcomes occurred from this practice. Ambulatory residents have the potential be affected by this practice.	

OLITILI	OT OIL MEDIO, IILE G	WEDIO/ ND OLIVIOLO				CIVID INC	7. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						R	-C
		495109	B. WING			06/	01/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF UNIVERSITY PA	ARK			420 PEMBERTON RD LICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 465	the facility was condup.m. an observation of Unit shower room. The Unit shower room. The Unit shower room. The Unit shower room is an unlocked. A 32-ounce Neutral one-step dising an unlocked cabinet in than 750 ml (milliliters). On 5/31/17 at 12:11 pconducted with RN (non Jefferson Unit. Woresponsible for ensurup in the cabinet in the stated, "We are all resulting assistants) are responsible for locking are done." On 5/31/17 at 12:12 pfollow this writer into room. RN #1 opened isn't locked." When a	o.m., general observation of loted. On 5/31/17 at 12:10 was made of the Jefferson he shower room door was to bottle of Super HDQ infectant spray was found in in the shower room. More so of liquid was in the bottle. o.m., an interview was registered nurse of liquid was in the bottle. o.m., an interview was registered nurse of liquid was in the bottle. o.m., an interview was registered nurse of liquid was in the bottle. o.m., an interview was registered nurse of liquid was in the bottle. o.m., an interview was registered nurse of liquid was in the bottle. o.m., an interview was registered nurse of liquid was in the bottle. o.m., an interview was registered nurse of liquid was in the bottle. o.m., an interview was registered nurse of liquid was in the bottle. o.m., an interview was registered nurse of liquid was in the bottle. o.m., an interview was registered nurse of liquid was in the bottle. o.m., an interview was registered nurse of liquid was in the bottle. o.m., an interview was registered nurse of liquid was in the bottle.	F	465	DON or designee will educate departm managers, the nursing department, and the housekeeping department on lockir shower cabinets and other areas that hazardous chemicals are stored. The DON or designee will conduct rour on all shower rooms, housekeeping call and other storage areas with hazardous chemicals for proper storage and that the are locked. Corrections will be made as appropriate and will be reported to the DON. Nursing administration will round on shower rooms weekly for 4 weeks to assure that the cabinet doors remain locked. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON the quality assurance committee. Continued compliance will be monitore through the facility squality assurance.	d ng nds rts, s hey s d. to	
	RN #1 stated that the hazardous if ingested thought residents cou spray, RN #1 stated, not in a wheelchair, the	e hazardous to residents, disinfectant spray was When asked if she ld reach the disinfectant "If a resident walks and is ney could reach it. If they don't think they could."			program. Additional education and monitoring will be initiated for any identified concerns. Completion date: June 23, 2017		
	staff member) #1, the aware of the above fil	_					
	On 5/31/17 at approx	imately 1:40 p.m., ASM #1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		405400	D WING				t-C	
NAME OF D		495109	B. WING _	OTDI	TET ADDRESS OUTV. STATE, 71D CODE	06/	01/2017	
NAME OF PROVIDER OR SUPPLIER					EET ADDRESS, CITY, STATE, ZIP CODE			
THE LAURELS OF UNIVERSITY PARK				RICHMOND, VA 23233				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION :		HOULD BE COMPLET		
F 465	Continued From page	e 24	F4	165				
	stated that she could chemicals.	not find a policy on storing						
	OUT OF REACH OF Causes irreversible e Harmful if swallowed, through the skin. Avonot get in eyes, on sk goggles or face shield protective clothing what thoroughly with soap and before eating, dri	wing information: "KEEP CHILDREN. Corrosive. ye damage and skin burns. inhaled or absorbed bid breathing spray mist. Do in, or on clothing. Wear d, rubber gloves and						
	Sheets) documented "Hazard Statements: Harmful if inhaled. Caserious eye damage. reaction. Precautiona and any exposed skir Do not eat, drink, or sproduct. Use only out area. Do not breathe protective gloves. We Wear protective cloth call a poison control of IN EYES: Rinse cauti minutes. Remove cor easy to do. Continue (or hair): Take off immolothing. Rinse skin wo contaminated clothing INHALED: Remove verest in a position com	May cause an allergic skin ry statements: Wash hands in thoroughly after handling. It was a more of the first transfer of the first						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495109	B. WING				-C
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK				S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 420 PEMBERTON RD ICHMOND, VA 23233	<u> U6/</u>	01/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 465	Continued From page NOT Induce vomiting	e 25 Storage: Store locked up."	F4	165			
{F 514} SS=D	483.70(i)(1)(5) RES	was presented prior to exit. TE/ACCURATE/ACCESSIB	{F 5	14}			6/23/17
	standards and practic	n accepted professional es, the facility must ords on each resident that					
	(i) Complete;						
	(ii) Accurately docume	ented;					
	(iii) Readily accessible	e; and					
	(iv) Systematically org	ganized					
	(5) The medical recor	d must contain-					
	(i) Sufficient information	on to identify the resident;					
	(ii) A record of the res	ident's assessments;					
	(iii) The comprehension provided;	ve plan of care and services					
	(iv) The results of any and resident review e determinations condu						
	(v) Physician's, nurse professional's progres						
	(vi) Laboratory, radiol	ogy and other diagnostic					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		495109	B. WING		1	R-C 6/01/2017	
NAME OF P	ROVIDER OR SUPPLIER	100.00		STREET ADDRESS, CITY, STATE, ZIP CODE		6/01/201/	
				2420 PEMBERTON RD			
THE LAUF	RELS OF UNIVERSITY P	ARK		RICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 514}	Continued From page	e 26	{F 51	4}			
	•	equired under §483.50. Fis not met as evidenced					
	Based on observation	n, staff interview and clinical determined that the facility		Ftag 514			
	staff failed to maintai clinical record for one survey sample, Resident #109's non-complian. The findings include: Resident #109 was re 5/19/17. Resident #7 were not limited to: h infections and seizur most recent MDS (massessment with an idate) of 3/6/17 coded cognitively intact. Review of Resident #7 revealed a physician the physician on 5/26	n a complete and accurate of 14 residents in the dent #109. If to document Resident ce with a bed alarm. Headmitted to the facility on 109's diagnoses included but high blood pressure, skin e disorder. Resident #109's inimum data set), an annual ARD (assessment reference of the resident as being head order summary signed by		Resident #109: No negative or occurred as a result of this pra Documentation has been mad medical record to reflect non cowith fall devices. All residents with non compliar interventions or other behavior potential to be affected by this DON or designee will educate nursing staff, and social service documentation in progress not residents with non compliance interventions. Nursing administration will aud documentation in the medical residents with orders for safety and documentation of any non compliance with the alarms. Owill be made as appropriate ar	actice. e in the compliance ace with fall as have the practice. licensed as staff on as staff on as for with fall dit accord for y alarms accorrections		
	alarm. Observations of Resi on 5/31/17 at 3:10 p. a.m. During both obswas observed lying in disconnected. Review of nurses' no 5/31/17 failed to reverse Resident #109 was no	dent #109 were conducted m. and on 6/1/17 at 7:55 servations, Resident #109 n bed and the bed alarm was tes from 5/19/17 through al any documentation that on-compliant with the bed 9's comprehensive care plan		reported to the DON. Nursing administration will commonitor by review of new order alarms 5 days a week weekly to Concerns will be reported by the quality assurance committee. Continued compliance will be a through the facility squality a program. Additional education monitoring will be initiated for a	ntinue to rs for safety for 4 weeks. he DON to ee. monitored ssurance and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NI IMBED:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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		495109	B. WING _		06/01/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE
THE LAUF	RELS OF UNIVERSITY PA	ARK		2420 PEMBERTON RD	
				RICHMOND, VA 23233	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE COMPLETION DATE
{F 514}	Continued From page	e 27	{F 51	4}	
		of 5/31/17 documented,		identified concerns.	
	check placement and	I related injuryBed alarm function every shift" The cument Resident #109 was e bed alarm.		Completion date: June 23, 2017	
	LPN #1 stated she had Resident #109 discont had seen him "mess wastated she had heard Resident #109 had dit past. When asked if the stated she had be stated to be stated to be stated to be stated she had be stated to be stated	licensed practical nurse) #1. Ind never personally seen Innect the bed alarm but she With" the alarm. LPN #1 If from other staff that Is sconnected the alarm in the			
	staff member) #1 (the aware of the above fir documentation was re p.m., ASM (administra director of nursing) sta the requested policy.	m., ASM (administrative administrator) was made ndings. A policy regarding equested. On 6/1/17 at 1:30 ative staff member) #2 (the ated the facility did not have a was presented prior to exit.			