STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/31/17 through 2/2/17. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 120 certified bed facility was 117 at the time of the survey. The survey sample consisted of 22 current resident reviews (Residents #1 through #21 and #29) and 7 closed record reviews (Residents #22 through #28).	F 000		
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 155		3/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/17/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that facility staff failed to clarify advanced directive preferences for three of 29 residents in the survey sample, Resident #10, #3, and #2.	F 155	The Laurels of Willow Creek wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is March 17, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 2 1. The facility staff failed to clarify advanced directives for Resident #10, when he had a signed DNR (Do Not Resuscitate) form in the clinical record but also had an order for FULL CODE on the most recent POS (Physician Order Sheet) dated 1/4/17. 2. The facility staff failed to clarify advanced directives for Resident #3, when she had both a signed DNR and FULL CODE form in her clinical record and an order for FULL CODE on her most recent POS dated 1/2/17. 3. The facility staff failed to clarify the code status for Resident # 2, when the resident had a DDNR (Durable Do Not Resuscitate Order) dated 10/19/16, signed by the physician and RP (responsible party) in the clinical record and the most recent POS (physician order sheet) dated 01/04/17 documented, "Code Status: Full Code." The findings include: 1. The facility staff failed to clarify advanced directives for Resident #10, when he had a signed DNR (Do Not Resuscitate) form in the clinical record but also had an order for FULL CODE on the most recent POS (Physician Order Sheet) dated 1/4/17. Resident #10 was admitted to the facility on 3/5/15 with diagnoses that included but were not limited to high blood pressure, cirrhosis of the liver, osteoporosis, mild intellectual difficulties and history of falls. Resident #10's most recent MDS (minimum data set) was a quarterly assessment	F 155	Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity 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 155 The code status was clarified for residents #2, #3, and #10. The Medical Records Coordinator will do an audit of all current medical records, and changes will be made as needed to clarify resident code status. The Director of Nursing/designee will provide in-service education to licensed nursing, social services, and admission staff on the proper documentation of resident code status. The Medical Records Coordinator will audit all new admission code status weekly for the next four weeks. Corrections and additional training will be provided as indicated. Continued compliance will be monitored through random reviews of resident code status. Any variances will be reported to the DON, and the DON will report to the QA Committee. Additional education and monitoring will be initiated for any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 3 with an ARD (assessment reference date) of 11/22/16. Resident #10 was coded as being cognitively intact in the ability to make daily decisions scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #10 was coded as requiring limited assistance from one staff member with transfers, locomotion, dressing, eating, toileting, and personal hygiene; and total dependence on staff with bathing. Review of Resident #10's clinical record revealed a sticker inside the front cover of the binder that documented, "DNR" (Do Not Resuscitate). This sticker had the Resident's name (Resident #10) written on it. Further review of the clinical record revealed a "Durable Do Not Resuscitate Order" dated 3/5/15 that documented the following: "I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above (Resident #10). I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify...2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment because he/she is unable to determine the nature, extent, or probable consequence of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision...I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation,	F 155	identified concerns.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 4	F 155		

and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct personnel to provide the patient other medical interventions, such as fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain." This from was signed by the POA (power of attorney).

Review of Resident #10's most recent POS (Physician Order Sheet) signed by the physician on 1/4/17 documented the following order: "CODE STATUS; FULL CODE." This order was initiated on 3-5-15.

On 2/1/17 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked where she looks to identify a resident's code status, LPN #3 pointed to the sticker on the inside of the chart and stated, "The code status is in the front of the chart."

On 2/2/17 at 8:55 a.m., an interview was conducted with LPN #5 and LPN #4. When asked about the process that staff follows for determining a resident's code status, LPN #5 stated that upon admission a resident's code status is determined by the code status they had in the hospital. LPN #5 also stated that admissions will ask the resident or responsible party about advanced directive preferences. LPN #5 stated that the advanced directive form is in the resident's admission packet. LPN #4 stated that if a resident wishes to be a DNR (Do Not Resuscitate), that the physician will be made aware and two nurses will sign the DNR form along with the responsible party. From there, an order is written and the doctor will sign the order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 5	F 155		

and form when he/she comes into the facility. The advanced directive form along with a sticker documenting code status is then placed in the clinical record. When asked about the process staff follows if a resident wishes to change their code status, LPN #5 stated that advanced directives are discussed in every care plan meeting and if the resident or RP (responsible party) wishes to change their directives, the same process is followed. LPN #5 stated that the social worker will call families or speak with the resident yearly to discuss advanced directives if these families or residents do not attend care plan meetings. LPN #5 stated that advanced directives are also discussed with the family or resident by the physician if the resident is having a decline in health condition. LPN #5 stated the sticker, advanced directive form and order should all match.

On 2/2/17 at 9:16 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked about the process staff follows for determining residents' advanced directives, ASM #2 stated that the code status is determined by the code status they had in the hospital. ASM #2 stated that if the resident does not come to the facility with a code status, the resident will automatically become a Full Code. The facility will then get in touch with the family or resident to determine their advanced directive preferences. ASM #2 stated that two nurses have to witness and sign a verbal order for the resident's advanced directive preference. ASM #2 stated that the physician will then come in and sign the physician's orders for DNR or Full Code and the DNR form if the resident chooses to be a DNR. ASM #2 stated that if they family or resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 6	F 155		

cannot decide advanced directive preferences, nursing staff and the physician will educate the resident and family about their options. When asked how the facility ensures accuracy of advanced directive preferences, ASM #2 stated the medical records will do periodic checks of the clinical records to ensure accuracy of advanced directives. ASM #2 stated the medical records ensure advanced directives match the physician's orders. ASM #2 then confirmed that Resident #10's advanced directives did not match his physician orders. When asked if Resident 10 was supposed to be a DNR or Full Code, ASM #2 stated that she thought he was supposed to be a DNR.

On 2/2/17 at 9:24 a.m., an interview was conducted with OSM (other staff member) #3, medical records. OSM #3 stated that she checks all resident's charts on a monthly basis for accuracy of advanced directives. OSM #3 also stated that she checks accuracy of advanced directives when the resident is admitted and as needed. OSM #3 stated that she ensures the sticker on the clinical record matches with the advanced directive form and physician's order. OSM #3 stated that if there is a discrepancy, she will notify the unit manager. OSM #3 stated that she did not notice that Resident #10's advanced directives did not match his physician's orders.

On 2/2/17 at 9:16 a.m., ASM #2 was made aware of the above concern.

Facility policy titled, "No CPR/Durable DO NOT RESUSCITATE (DNR) ORDERS," documents in part, the following: "It is the policy of this facility to respect and encourage guest self-determination. This facility recognizes it is the right of any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 7 competent guest or person designated as their authorized agent for making health decisions for a guest, to request that cardiopulmonary resuscitation (CPR) be withheld in the event of cardiac or respiratory arrest. PROCEDURE: The Social Service Director or his/her designee will have a discussion with the guest and/or guest's legal representative regarding the decision to have a do not resuscitate order. 2. The Social Service Director will document the conversation in the Social Services progress notes. 3. If the guest and/or guest's legal representative desire to initiate a "Do Not Resuscitate" order, the Director of Nursing or his/her designee shall notify the attending physician. 4. The physician, who has a bona fide physician/patient as defined by the Virginia Board of Medicine, will discuss the Durable DNR and its provisions with the guest and/or legal representative, to include the consequences of initiating a Durable DNR order. The physician shall document this discussion in the progress notes. 5. If the guest and/or guest's legal representative proceed with the initiation of a Durable Do Not Resuscitate order, the following forms will be completed and placed in the front of guest's medical record: a. A valid Durable DNR form printed of distinctive paper by the Virginia Department of health containing the following information: 1. A Do Not Resuscitate determination 2. Signature of the Physician 3. Signature of guest if applicable 4. Signature of Designated Agent for the guest or Authorized Decision Maker 5. Date of issuance 6. Effective period for a signed Durable DNR order form shall remain valid until revoked 6. Complete the Emergency Response Directive and place in the guest's medical record with the valid DNR form..."	F 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 8 2. The facility staff failed to clarify advanced directives for Resident #3, when she had both a signed DNR and FULL CODE form in her clinical record and an order for FULL CODE on her most recent POS dated 1/2/17. Resident #3 was admitted to the facility on 8/6/15 with diagnoses that included but were not limited to high blood pressure, diabetes, high cholesterol, stroke, hemiplegia (one sided paralysis), depression, chronic kidney disease, anxiety disorder and auditory/visual hallucinations. Resident #3's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/13/16. Resident #3 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance from two or more staff members with transfers, dressing, eating, toileting, and personal hygiene; and totally dependent on staff with locomotion and bathing. Review of Resident #3's clinical record revealed a sticker inside the front cover of the binder that documented, "DNR" (Do Not Resuscitate). This sticker had the Resident's name (Resident #3) written on it. Further review of the clinical record revealed a "Durable Do Not Resuscitate Order" dated 9/16/05 that documented the following: "I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above (Resident #3). I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's	F 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 9	F 155		

behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify...1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment...I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation, and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct personnel to provide the patient other medical interventions, such as fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain." This from was signed by Resident #3.

Review of the clinical record also revealed an "Emergency Response Directive" for Resident #3. The following was documented, "Resuscitation: I understand if my heart stops or my breathing stops, cardiopulmonary resuscitation (CPR) will be attempted, with emergency transportation to the hospital where full life support measures may be undertaken. This form was signed by the resident on 8/12/15 documenting that she wanted Resuscitation.

Review of Resident #3's POS (Physician Order Sheet) dated 1/2/17 documented the following order: "CODE STATUS; FULL CODE." This order was initiated on 8/13/15.

On 2/1/17 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked where she looks to identify a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 10	F 155		

resident's code status, LPN #3 pointed to the sticker on the inside of the chart and stated, "The code status is in the front of the chart."

On 2/2/17 at 8:55 a.m., an interview was conducted with LPN #5 and LPN #4. When asked about the process staff follows for determining a resident's code status, LPN #5 stated that upon admission a resident's code status is determined by the code status they had in the hospital. LPN #5 also stated that admissions will ask the resident or responsible party about advanced directive preferences. LPN #5 stated that the advanced directive form is in the resident's admission packet. LPN #4 stated that if a resident wishes to be a DNR (Do Not Resuscitate), that the physician will be made aware and two nurses will sign the DNR form along with the responsible party. From there, an order is written and the doctor will sign the order and form when he/she comes into the facility. The advanced directive form along with a sticker documenting code status is then placed in the clinical record. When asked about the process staff follows when a resident wishes to change their code status, LPN #5 stated that advanced directives are discussed in every care plan meeting and if the resident or RP (responsible party) wishes to change their directives, the same process is followed. LPN #5 stated that the social worker will call families or speak with the resident yearly to discuss advanced directives if these families or residents do not attend care plan meetings. LPN #5 stated that advanced directives are also discussed with the family or resident by the physician if the resident is having a decline in health condition. LPN #5 stated the sticker, advanced directive form and order should all match.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 11 On 2/2/17 at 9:16 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked about the process staff follows for determining advanced directives, ASM #2 stated that the code status is determined by the code status they had in the hospital. ASM #2 stated that if the resident does not come to the facility with a code status, the resident will automatically become a Full Code. The facility will then get in touch with the family or resident to determine their advanced directive preferences. ASM #2 stated that two nurses have to witness and sign a verbal order for the resident's advanced directive preference. ASM #2 stated that the physician will then come in and sign the physician's orders for DNR or Full Code and the DNR form if the resident chooses to be a DNR. ASM #2 stated that if they family or resident cannot decide advanced directive preferences, nursing staff and the physician will educate the resident and family about their options. When asked how the facility ensures accuracy of advanced directive preferences, ASM #2 stated the medical records will do periodic checks of the clinical records to ensure accuracy of advanced directives. ASM #2 stated the medical records ensure advanced directives match the physician's orders. ASM #2 then confirmed that Resident #3's advanced directives did not match his physician orders. On 2/2/17 at 9:24 a.m., an interview was conducted with OSM (other staff member) #3, medical records. OSM #3 stated that she checks all resident's charts on a monthly basis for accuracy of advanced directives. OSM #3 also stated that she checks accuracy of advanced directives when the resident is admitted and as	F 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 12	F 155		

needed. OSM #3 stated that she ensures the sticker on the clinical record matches with the advanced directive form and physician's order. OSM #3 stated that if there is a discrepancy, she will notify the unit manager. OSM #3 stated that she did not notice that Resident #3's advanced directives did not match his physician's orders. When asked if Resident #3 was a DNR or Full Code, OSM #3 stated, "I really don't know."

On 2/2/17 at 9:16 a.m., ASM #2 was made aware of the above concerns.

3. The facility staff failed to clarify the code status for Resident # 2, when the resident had a DDNR (Durable Do Not Resuscitate Order) dated 10/19/16, signed by the physician and RP (responsible party) in the clinical record and the most recent POS (physician order sheet) dated 01/04/17 documented, "Code Status: Full Code."

Resident # 2 was admitted to the facility on 10/18/16 with diagnoses that included but not limited to: anemia (1), hypothyroidism (2), urinary tract infection (3), dementia (4), anxiety (5), Meniere's disease (6), heart failure and depression.

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/12/17 coded Resident # 2 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 being moderately impaired of cognition. Resident # 2 was coded as requiring extensive assistance of one staff member for activities of daily living.

Review of Resident # 2's clinical record on 1/31/17 at 2:30 p.m. revealed a red sticker that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 13	F 155		

documented DNR (Do Not Resuscitate) on the inside cover of the clinical record. Further review of the clinical record revealed a "DDNR (Durable Do Not Resuscitate Order)" for Resident # 2 dated 10/19/16, which was signed by the physician and Resident # 2's responsible party.

The POS (physician order sheet) for Resident # 2 dated 01/04/17 documented, "Code Status: Full Code."

On 01/31/17 at 2:55 p.m. an interview was conducted with LPN (licensed practical nurse) # 3. When asked how they know a resident's code status LPN # 3 stated, "It's on the inside of the chart, it's a sticker

On 01/31/17 at 3:30 p.m. an interview was conducted with LPN # 4. When asked about the process of establishing a resident's code status, LPN # 4 stated, "If they come in from the hospital we follow that code status unless the physician or family requests something else. If they do request something else, the physician will speak with the family about the code status and write an order. If they come in without a code status, they are automatically a full code unless the family wants it changed. If they want a DNR two nurses will verify the code status with the family by each of the nurses speaking with the family at separate times."

On 02/02/17 at 9:16 a.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked about the process of establishing a resident's code status, ASM # 2 stated, 'Sometimes the code status comes from the hospital. If they come in without a code status,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 14	F 155		

they are automatically a full code unless the family wants it changed. If they want a DNR two nurses will verify the code status with the family by each of the nurses speaking with the family at separate times." When asked who ensures the accuracy of the resident's code status, ASM # 2 stated, "Medical records do a check to make sure the chart is accurate for the code status." ASM # 2 was asked to review Resident # 2's clinical record, POS and DDNR. ASM # 2 acknowledged the discrepancy of Resident # 2's code status.

On 02/02/17 at 9:24 a.m. an interview was conducted with OSM # 3, director of medical records. When asked how often the resident's clinical record is reviewed for accuracy, OSM # 3 stated, "Monthly and any time it needs to be done." When asked about the process of checking the accuracy of the code status, OSM # 3 stated, "I check the sticker on the front cover of the chart and the advance directive to make sure they match and if they don't I notify the unit manager." After reviewing Resident # 2's clinical record, POS and DDNR, OSM # 3 stated that a review of Resident # 2's clinical record had been done, didn't remember when it was done and didn't notice the discrepancy in the code status. OSM # 3stated, "It was an oversight."

On 02/01/17 at 4:45 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings.

No further information was obtained prior to exit.

References:
(1) Low iron. This information was obtained from the website:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 15 https://www.nlm.nih.gov/medlineplus/anemia.html . (2) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html. (3) An infection in the urinary tract. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm. (4) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html. (5) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (6) An inner ear disorder that affects balance and hearing. This information was obtained from the website: https://medlineplus.gov/ency/article/000702.htm.	F 155		
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate	F 278		3/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 16 participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility failed to complete an accurate MDS (minimum data set) assessment for four of 29 residents in the survey sample, Resident # 2, # 5, # 9, # 10 and # 7. 1. The facility staff failed to accurately document the correct date of Resident # 2's influenza vaccination on the quarterly MDS (minimum data set) assessment with an ARD (assessment	F 278	The MDS for residents #2 and #7 have been corrected. A new MDS has been completed for residents #9 and #10 to include the required activity interview and pain management. The MDS Coordinator/ designee will audit the MDS of all current residents and correct any variances related to influenza vaccinations, activity interviews, pain	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 17 reference date) of 01/12/17. 2. The facility staff failed to complete the activity interview on Resident # 9's admission MDS (Minimum Data Set) assessment with the ARD of 12/03/16. 3. For Resident #10, facility staff failed to properly code Section J. "Pain Management," on his quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/22/16. 4. The facility staff entered an incorrect weight for Resident #7 on the 8/5/16 admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 8/5/16. The findings include: 1. The facility staff failed to accurately document the correct date of Resident # 2's influenza vaccination on the quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/12/17. Resident # 2 was admitted to the facility on 10/18/16 with diagnoses that included but not limited to: anemia (1), hypothyroidism (2), urinary tract infection (3), dementia (4), anxiety (5), Meniere's disease (6), heart failure and depression. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/12/17 coded Resident # 2	F 278	management and current weight. Corrections will be made when appropriate and continuing education provided as needed. The Regional Clinical Resource Specialist will in-service the MDS staff and Activity Director on coding accuracy related to activity interviews, flu vaccines, weight, and pain. The MDS Coordinator / designee will review each comprehensive MDS prior to submission for the next 4 weeks to ensure completion and accuracy. Variances will be corrected as identified and concerns will be reported to the monthly quality assurance meeting. Continued education will be provided as needed. The MDS Coordinator /designee will continue to monitor for compliance through random review of MDS for pain, weights, activity interviews, and flu vaccine coding. Results of any variances will be reported to the DON and the DON will forward to the QA Committee. Additional education and monitoring will be initiated for any identified concerns.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 18	F 278		

as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 being moderately impaired of cognition. Resident # 2 was coded as requiring extensive assistance of one staff member for activities of daily living. Section B0700 "Makes Self Understood" coded Resident # 2 as "Usually understood" and section B0800 "Able To Understand Others" coded Resident # 2 as "Understands - clear comprehension." Section O0250 "Influenza Vaccination" coded resident # 2 a "0 (zero). No. - Skip to O0250C, If influenza vaccine not received, state reason." Under section O0250C Individual # 2 was coded "4 (four). Offered and declined."

Review of Resident # 2's clinical record revealed an "Immunization Record". The immunization record documented the influenza vaccination given with consent in the right deltoid on 11/23/16 and signed by the nurse on "11/23/16."

On 02/01/17 at 2:00 p.m. an interview was conducted with RN (registered nurse) # 1, MDS coordinator. RN # 1 was asked to review Section O0250 "Influenza Vaccination" of Resident # 2's quarterly MDS with the ARD of 01/12/17 and the "Immunization Record" for Resident # 2. When asked about the discrepancy between the MDS and the immunization record for Resident # 2, RN # 1 stated, "The flu is not coded correctly." When asked what reference is used for completing the MDS RN # 1 stated she uses the RAI (Resident Assessment Instrument) manual.

The RAI (Resident Assessment Instrument) manual documented, " O0250: Influenza Vaccine. Steps for Assessment
1. Review the resident's medical record to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 19	F 278		

determine whether an influenza vaccine was received in the facility for this year's influenza vaccination season. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if he or she received an influenza vaccine outside of the facility for this year's influenza vaccination season. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If influenza vaccination status is still unknown, proceed to the next step.
4. If influenza vaccination status cannot be determined, administer the influenza vaccine to the resident according to standards of clinical practice.
Coding Instructions for O0250A, Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?
o Code 0, no: if the resident did NOT receive the influenza vaccine in this facility during this year's influenza vaccination season. Proceed to If influenza vaccine not received state reason (O0250C).
o Code 1, yes: if the resident did receive the influenza vaccine in this facility during this year's influenza season. Continue to Date influenza vaccine received (O0250B).
Coding Instructions for O0250B, Date influenza vaccine received
o Enter the date that the influenza vaccine was received. Do not leave any boxes blank.
- If the month contains only a single digit, fill in the first box of the month with a "0". For example, January 17, 2014 should be entered as 01-17-2014.
- If the day only contains a single digit, then fill the first box of the day with the "0". For example,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 20 October 6, 2013 should be entered as 10-06-2013. A full 8 character date is required. - A full 8 character date is required. If the date is unknown or the information is not available, only a single dash needs to be entered in the first box. Coding Instructions for O0250C, If influenza vaccine not received, state reason If the resident has not received the influenza vaccine for this year's influenza vaccination season (i.e., O0250A=0), code the reason from the following list: o Code 1, Resident not in this facility during this year's influenza vaccination season: resident was not in this facility during this year's influenza vaccination season. o Code 2, Received outside of this facility: includes influenza vaccinations administered in any other setting (e.g., physician office, health fair, grocery store, hospital, fire station) during this year's influenza vaccination season. o Code 3, Not eligible-medical contraindication: if influenza vaccine not received due to medical contraindications. Contraindications include, but are not limited to; allergic reaction to eggs or other vaccine component(s) (e.g., thimerosal preservative), previous adverse reaction to influenza vaccine, a physician order not to immunize, moderate to severe illness with or without fever, and/or history of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination. o Code 4, Offered and declined: resident or responsible party/legal guardian has been informed of the risks and benefits of receiving the influenza vaccine and chooses not to accept vaccination. o Code 5, Not offered: resident or responsible party/legal guardian not offered the influenza vaccine.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 21	F 278		

o Code 6, Inability to obtain influenza vaccine due to a declared shortage: vaccine is unavailable at this facility due to a declared influenza vaccine shortage.
o Code 9, None of the above: if none of the listed reasons describe why the influenza vaccine was not administered. This code is also used if the answer."

On 02/01/17 at 4:45 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings.

No further information was obtained prior to exit.

References:
(1) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(2) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.

(3) An infection in the urinary tract. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm.

(4) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 22 (5) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (6) An inner ear disorder that affects balance and hearing. This information was obtained from the website: https://medlineplus.gov/ency/article/000702.htm. 2. The facility staff failed to complete the activity interview on Resident # 9's admission MDS (Minimum Data Set) assessment with the ARD of 12/03/16. Resident # 5 was admitted to the facility on 03/17/15 with diagnoses that included but were not limited to: coronary artery disease (1), hypertension (2), Alzheimer's disease (3), hallucinations (4) and muscle weakness. Review of the MDS, an admission assessment, with an ARD of 12/03/16 coded Resident # 9 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three being severely impaired of cognition for daily decision making. Resident # 9 was coded as requiring extensive assistance of one staff member for activities of daily living. Section B0700 "Makes Self Understood" coded Resident # 9 as "Usually understood" and section B0800 "Able To Understand Others" coded Resident # 9 as "Usually understands." Section F0300 "Preferences for Customary Routine and Activities" of the admission MDS	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 23	F 278		

assessment with an ARD of 12/03/16, documented, ("Should Interview for Preferences for Customary Routine and Activities be conducted? - Attempt to conduct interview residents able to communicate") and was coded with a dash mark. Review of Sections F0400 "Interview for Daily Preferences," F0500 "Interview for Activity Preferences," and F0600 "Daily and Activity Preferences Primary Respondent" were coded with dash marks. Section F0800 "Staff Assessment of Daily and Activity Preferences" was not completed.

On 02/01/17 at 2:00 p.m., an interview was conducted with RN (registered nurse) # 1, MDS coordinator, regarding the dashes coded in the activity interview section of Resident # 9's admission MDS assessment with the ARD of 12/03/16. After reviewing the MDS assessment, RN # 1 stated, "The section was coded incorrectly. The dashes mean the interview wasn't done." When asked who completed the activity interview section of Resident # 9's admission MDS assessment, RN # 1 stated, "It was completed by (OSM [other staff member] # 1), activities director. RN # 1 further stated that they follow the RAI (resident assessment instrument) manual.

On 02/02/17 at 9:55 a.m., an interview was conducted with OSM # 1, director of activities. After reviewing the admission MDS assessment with the ARD of 12/03/16 for Resident # 9, OSM # 1 was asked about the dashes coded in the activity interview section. OSM # 1 stated, "That section was completed by the previous activity director and they're no longer here."

The RAI (Resident Assessment Instrument)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 24	F 278		

manual documented, "SECTION F: PREFERENCES FOR CUSTOMARY ROUTINE AND ACTIVITIES. Intent: The intent of items in this section is to obtain information regarding the resident's preferences for his or her daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. The information obtained during this interview is just a portion of the assessment. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences, and is not meant to be all-inclusive."

On 02/01/17 at 4:45 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings.

No further information was obtained prior to exit.

References:
(1) A common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(3) A brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 25 (4) Involve sensing things such as visions, sounds, or smells that seem real but are not. These things are created by the mind. This information was obtained from the website: https://medlineplus.gov/ency/article/003258.htm. 3. For Resident #10, facility staff failed to properly code Section J. "Pain Management," on his quarterly MDS assessment (minimum data set) with an ARD (assessment reference date) of 11/22/16. Resident #10 was admitted to the facility on 3/5/15 with diagnoses that included but were not limited to high blood pressure, cirrhosis of the liver, osteoporosis, mild intellectual difficulties and history of falls. Resident #10's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/22/16. Resident #10 was coded as being cognitively intact in the ability to make daily decisions scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #10 was coded as requiring limited assistance from one staff member with transfers, locomotion, dressing, eating, toileting, and personal hygiene; and total dependence on staff with bathing. Review of Resident #10's quarterly MDS assessment with an ARD of 11/22/16 documented the following under Section J, "Pain Management": "J0200. Should Pain Assessment Interview be conducted? Attempt to conduct interview with all residents. If resident is comatose, skip to J1100,	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 26 Shortness of Breath (dyspnea) 0. No (resident is rarely/never understood) --> (Arrow) skip to and complete J0800, Indicators of Pain or Possible Pain. 1. Yes --> (Arrow) Continue to J0300, Pain Presence." A "1" was coded indicating a Pain assessment should be conducted. Section J0300. "Pain Presence" documented the following: "Ask resident: "Have you had pain or hurting at any time in the last 5 days?" 0. No --> (arrow) Skip to J1100, Shortness of Breath 1. Yes -->(arrow) Continue to J0400, Pain Frequency 9. Unable to answer --> (arrow) Skip to J0800, Indicators of Pain or Possible Pain." A "-" (dash) was coded indicating that this area was not assessed. Section J0400. "Pain Frequency" documented the following: "Ask resident: How much of the time have you experienced pain or hurting over the last 5 days?" 1. Almost constantly 2. Frequently 3. Occasionally 4. Rarely 5. Unable to answer" A "-" (dash) was coded indicating that this area was not assessed. Section J0500a. "Pain Effect on Function"	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 27 documented the following: "Ask resident: Over the past 5 days, has pain made it hard for you to sleep at night? 0. No 1. Yes 9. Unable to answer" A "-" was coded indicating that this area was not assessed. Section J0500b. documented the following: "Ask resident: Over the past 5 days, have you limited your day-to-day activities because of pain? 0. No 1. Yes 9. Unable to answer" A "-" (dash) was coded indicating that this area was not assessed. Section J0600. "Pain Intensity" documented the following: "Administer only one of the following pain intensity questions (A or B) A. Numeric Rating Scale (00-10) Ask resident: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst possible pain you can imaging." Enter two digit response. Enter 99 if unable to answer." A "-" (dash) was coded indicating that this area was not assessed. "B. Verbal Descriptor Scale, Ask resident: Please rate the intensity if your worst pain over the last 5 days." 1. Mild 2. Moderate 3. Severe	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 28 4. Very severe, horrible 9. Unable to answer. A "-" (dash) was coded indicating that this section was not assessed. Further review of the quarterly MDS assessment with an ARD of 11-22-16 revealed that the Staff Assessment for Pain was completed. On 2/1/17 at 2:31 p.m., an interview was conducted with RN (Registered Nurse) #1, the MDS coordinator. When asked about the process of filling out Section J (Pain) on the MDS, RN #1 stated that if the Resident can answer the questions asked, the individual interview should be conducted. RN #1 stated that "-" dashes meant that the MDS was not completed. RN #1 stated, "It looks like the 11/22 pain assessment wasn't done. I am not sure who was assigned that section. The staff assessment was completed but the individual interview should have been done." RN #1 stated that MDS uses the RAI (Resident Assessment Instrument) manual as a reference. On 2/1/17 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. 4. The facility staff entered an incorrect weight for Resident #7 on the 8/5/16 admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 8/5/16.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 29	F 278		

Resident #7 was admitted to the facility on 7/28/16 and readmitted on 10/24/16 with diagnoses including, but not limited to: history of a stroke, chronic kidney disease, diabetes and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 10/31/16, Resident #7 was coded as being moderately cognitively impaired for making daily decisions. His weight was documented as 149 pounds.

A review of the admission MDS assessment with an assessment reference date of 8/5/16 for Resident #7 revealed a documented weight of 165 pounds.

A review of the dietary progress note revealed the following note written 8/2/16 by OSM (other staff member) #5, the RD (registered dietician): "Error in admit wt. (weight). 7/29/16 - 159. Re-weighed..."

On 2/1/17 at 3:35 p.m., RN (registered nurse) #1, the MDS coordinator, was interviewed. She stated that the dietician is responsible for putting weights in resident MDSs. When shown the 8/5/16 MDS assessment and the above-referenced RD progress note, RN #1 stated: "I was not aware that there was an error. If I had known, I would have done a corrected MDS assessment."

On 2/1/17 at 4:45 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

On 2/2/17 at 10:20 a.m., OSM (other staff member) #5, the RD, was interviewed. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 30 stated if she became aware that she had entered an incorrect weight on a resident's MDS assessment, she would notify the MDS coordinator. OSM #5 stated: "There needs to be a correction." She stated she did not remember whether or not she had told RN #1 about the inaccurate weight as recorded on Resident #7s 8/5/16 MDS assessment. No further information was provided prior to exit.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 279		3/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 31 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to develop a care plan from the triggered CAAs (Care Area Assessment) on MDS (minimum data set)	F 279	The care plan for residents #2, #5, and #8 were updated and reviewed during the course of the survey. All residents that trigger on the CAAs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 32 assessments for three of 29 residents, Resident #8, #5 and #2. 1. The facility staff failed to develop a dental care plan for Resident #8, to address the triggered area of dental care on the 12-21-16 admission MDS (minimum data set) assessment. 2. The facility staff failed to develop a comprehensive care plan for Resident #5 to address the triggered area of dental care in Section V (CAA) of the annual MDS assessment with an ARD of 12/21/16. 3. The facility staff failed to develop a comprehensive care plan for Resident # 2's weight loss The findings include: 1. The facility staff failed to develop a dental care plan for Resident #8, to address the triggered area of dental care on the 12-21-16 admission MDS (minimum data set) assessment. Resident #8 was admitted to the facility on 12/14/16 with diagnoses that included but were not limited to Parkinson's disease, muscle weakness, osteoarthritis, decrease WBC (white blood cell) count, high blood pressure, malaise, history of stroke, and high cholesterol. Resident #8's most recent MDS was a thirty day scheduled assessment with an ARD (assessment reference date) of 1/9/17. Resident #8 was coded as being cognitively intact in the ability to make daily decisions, scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8	F 279	have the potential to not be care planned. The MDS Coordinator/designee will complete an audit of all current residents with areas that trigger on the CAAS to ensure a comprehensive care plan has been implemented. Any variances will be corrected and continued education provided. The Regional Clinical Resource Specialist will in-service the MDS staff on the required care plans in relation to areas triggering on CAAs. The MDS Coordinator/ designee will review each new comprehensive MDS for the next 4 weeks to ensure completion and accuracy of the care plan related to areas triggering in the CAAs. Variances will be corrected as identified and reported to the DON who will report trends to the QA Committee. On-going compliance will be monitored through the routine review of care plans and through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 33	F 279		

was coded as requiring extensive assistance with one staff member with transfers, locomotion, dressing, eating, toileting, personal hygiene; and total dependence on staff with bathing.

Review of Resident #8's admission MDS assessment with an ARD of 12-21-16, revealed in Section V (Care Area Assessment Summary) the following triggered areas:

"ADL (Activities of Daily Living)
Functional/Rehabilitation Potential
Urinary Incontinence and Indwelling Catheter
Falls
Nutritional Status
Dental Care
Pressure Ulcer"

All above care areas were documented with an "X" under column B. (Care Planning Decision) indicating that these areas would be care planned for Resident #8.

"Dental Care" was a triggered care area that could not be found on Resident #8's care plan dated 12/16/16, with a documented updated date of 1/10/17.

On 2/1/17 at 2:33 p.m., an interview was conducted with RN (Registered Nurse) #2, the nurse who completed the 12/21/16 MDS assessment. When asked about the process of creating a care plan from the triggered CAAs on an MDS assessment, RN #2 stated, "Anytime the area triggers, I care plan it." When asked if RN #2 could find Resident #8's dental care plan, RN #2 stated, "I can't find it. I guess it must have been missed. I usually add it to nutrition." RN #2 stated that she uses the RAI (Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 34	F 279		

Assessment Instrument) manual as a reference when completing the MDS assessments and care plans.

On 2/1/17 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

"Section V: Care Area Assessment: V0200. CAAs and Care Planning
1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Addressed Care Plan column must be completed within 7 days of completing the RAI [MDS and CAA(s)]. Check column B if the triggered care area is addressed in the care plan."

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 35 plan. An out of date or incorrect care plan compromises the quality of nursing care. 2. The facility staff failed to develop a comprehensive care plan for Resident #5 to address the triggered area of dental care in Section V (CAA) of the annual MDS assessment with an ARD of 12/21/16. Resident # 5 was admitted to the facility on 03/17/15 with diagnoses that included but were not limited to: anemia (1), hypertension (2), gastroesophageal reflux disease (3), end stage renal disease (4), thyroid disorder (5) and dementia (6). Review of the MDS, an annual assessment, with an ARD of 12/21/16 coded Resident # 5 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 being moderately impaired of cognition. Resident # 5 was coded as requiring extensive assistance of one staff member for activities of daily living. Review of the comprehensive annual assessment with an ARD of 12/21/16 revealed in Section V - Care Area Assessment (CAA), that "15. Dental Care" was checked under the heading "B. Addressed in Care Plan." Review of Resident # 5's comprehensive care plan dated 12/22/16 did not evidence a care plan for Resident # 5's dental care. On 02/01/17 at 3:00 p.m. ASM (administrative staff member) # 2, director of nursing stated that	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 36	F 279		

they were unable to find a care plan for Resident # 5's dental care.

On 02/02/17 at 7:45 a.m. RN (registered nurse) # 1, MDS coordinator reviewed the care plan and the annual MDS assessment with the ARD of 12/21/16. RN # 1 stated that a dental care plan was developed for Resident # 5. At that time RN # 1 presented this surveyor with a dental care plan for Resident # 5 dated 02/02/17.

On 02/01/17 at 4:45 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings.

No further information was obtained prior to exit.

References:
(1) Low iron. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anemia.html
.

(2) High blood pressure. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website:
https://medlineplus.gov/ency/article/000500.htm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 37 (5) The thyroid is a butterfly-shaped gland in your neck, just above your collarbone. It is one of your endocrine glands, which make hormones that control the rate of many activities in your body. Problems include hypertension, hypothyroidism and thyroid cancer). This information was obtained from the website: https://medlineplus.gov/thyroiddiseases.html. (6) Dementia is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 3. The facility staff failed to develop a comprehensive care plan for Resident # 2's weight loss Resident # 2 was admitted to the facility on 10/18/16 with diagnoses that included but not limited to: anemia (1), hypothyroidism (2), urinary tract infection (3), dementia (4), anxiety (5), Meniere's disease (6), heart failure and depression. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/12/17 coded Resident # 2 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 being moderately impaired of cognition. Resident # 2 was coded as requiring extensive assistance of one staff member for activities of daily living. Section K "Swallowing / Nutritional Status" coded Resident # 2 as having an unplanned weight loss.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 38	F 279		

Review of Resident # 2's comprehensive care plan dated 10/25/16 failed to evidence a care plan for Resident # 2's weight loss.

On 02/01/17 at 4:00 p.m. RN (registered nurse) # 1, MDS coordinator reviewed the care plan and the quarterly MDS assessment with the ARD of 01/12/17. RN # 1 stated, "The weight loss was not put on the care plan." When asked who was responsible for ensuring the weight loss was put on the care plan, RN # 1 stated, "MDS or the dietician." When asked about the process followed to develop the care plan for Resident # 2's weight loss, RN # 1 stated, "When it's identified on the MDS I make sure it's put on the care plan. It was overlooked."

On 02/01/17 at 4:45 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings.

No further information was obtained prior to exit.

References:
(1) Low iron. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anemia.html
.

(2) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.

(3) An infection in the urinary tract. This information was obtained from the website:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 39 https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm. (4) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html. (5) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (6) An inner ear disorder that affects balance and hearing. This information was obtained from the website: https://medlineplus.gov/ency/article/000702.htm.	F 279		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in	F 371		3/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 40 accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to prepare and serve food in a sanitary manner. The food product table, meat slicer blade and the free standing mixer were observed with food debris present. The findings include: Observation of the kitchen was conducted on 01/31/17 at approximately 10:45 a.m. with OSM (other staff member) # 2, dietary manager. The following was observed: Observation of the food preparation table revealed a meat slicer. When asked if the meat slicer was cleaned and ready for use OSM # 2 stated, "Yes." Observation of the meat slicer revealed the blade and product table was observed to have food debris on it. OSM # 2 agreed with the findings. When asked if the free standing mixer was cleaned and ready for use OSM # 2 stated, "Yes." Observation of the free standing mixer revealed the neck and the beater shaft were observed to have food debris on it. Further review of the mixer revealed a whole, unpeeled, uncooked	F 371	The food product table, slicer blade, and mixer were cleaned during the course of the survey. The Dietary Manager conducted detailed kitchen rounds during the course of the survey, and corrections were made for any identified issues. The Dietary Manager will conduct in-service education with the Dietary staff on cleaning procedures and frequency related to mixers, slicers, and food product tables. The Dietary Manager will conduct sanitation rounds weekly for the next 4 weeks to ensure proper sanitation of mixers, slicers, and food product tables. Audits will continue randomly thereafter. Variances will be corrected as identified, and reported to the QA Committee. Continued education will be provided as needed. On-going compliance will be monitored through the routine dietary rounds and through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 41 potato lying in the mixing bowl. OSM # 2 stated that she didn't know how the potato ended up in the mixing bowl and agreed with the findings. The facility's policy "Meat Slicer" and "Mixer" both documented, "The meat slicer shall be cleaned and sanitized after each use." On 02/01/17 at 4:45 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings. No further information was obtained prior to exit.	F 371		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 514		3/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 42 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that facility staff failed to maintain a complete and accurate clinical record for four of 29 residents in the survey sample, Resident #14, #10, #3, and #2. 1. The facility staff filed a skin assessment sheet belonging to another resident, in Resident #14's clinical record. 2. The facility staff failed to maintain an accurate clinical record for Resident #10. Resident #10's clinical record contained both a signed DDNR (Durable Do Not Resuscitate) order, and an order for a FULL CODE on the most recent POS (Physician Order Sheet) dated 1/4/17. 3. The facility staff failed to maintain an accurate clinical record for Resident #3. Resident #3's clinical record contained advanced directives to be both a FULL CODE and DNR, and she had an order to be a FULL CODE on her most recent POS dated 1/2/17.	F 514	The code status was clarified for residents #2, #3, and #10, and the misfiled skin assessment in the chart of resident #14 has been refiled. The Medical Records Coordinator will do an audit of all current medical records, and changes will be made as needed to clarify resident code status, and to ensure that all pages are filed in the correct chart. The Director of Nursing/designee will provide in-service education to licensed nursing, social services, and admission staff on the proper documentation of resident code status and the filing of medical records. The Medical Records Coordinator will audit all new admission code status weekly, and random charts for filing accuracy for the next four weeks. Corrections and additional training will be provided as indicated. The results of the audits will be reviewed and the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 43 4. Resident #2's clinical record failed to accurately reflect the resident's code status. Resident # 2's clinical record contained a DDNR (Durable Do Not Resuscitate Order) dated 10/19/16, signed by the physician and RP (responsible party) in the clinical record and the most recent POS (physician order sheet) dated 01/04/17 documented, "Code Status: Full Code." The findings include: 1. The facility staff filed a skin assessment sheet belonging to another resident, in Resident #14's clinical record. Resident #14 was admitted to the facility on 10/22/13 with diagnoses that included but were not limited to heart failure, high blood pressure, aphasia, stroke, depression, stroke and muscle spasms. Resident #14's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/2/16. Resident #14 was coded as being cognitively intact in the ability to make daily decisions, scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #14 was coded as requiring extensive assistance from two staff members with transfers, dressing, toileting, and personal hygiene; limited assistance with meals; and total dependence on staff with bathing. Review of Resident #14's clinical record revealed a "Weekly Skin Assessment" sheet dated 11/3/16 through 12/1/16 that had another resident's name on the sheet. On 2/1/17 at approximately 10:00 a.m., ASM	F 514	Assurance Committee. Continued compliance will be monitored through random reviews of code status documentation and filing accuracy. Any variances will be reported to the DON, and the DON will report to the QA Committee. Additional education and monitoring will be initiated for any identified concerns.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 44	F 514		

(administrative staff member) #2 stated, "The skin assessment sheet belongs to (Name of the other resident); it was in (Name of Resident #14's) chart." When asked if the skin assessment sheet should have been in Resident #14's chart, ASM #2 stated, "No."

On 2/1/17 at 2:40 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #3. When asked who was responsible for filing weekly skin assessment sheets in the clinical record, LPN #3 stated that the unit secretary files skin sheets in the chart for both units.

On 2/1/17 at 2:43 p.m., an interview was conducted with OSM (other staff member) #6, the unit secretary. When asked who was responsible for filing weekly skin assessment sheets in the clinical record, OSM #6 stated that weekly skin sheets are kept in a blue binder, and when that week is over, the skin sheet is filed into the clinical record. OSM #6 stated that she did not file weekly skin assessment sheets on (name of wing in facility) (the wing Resident #3 resides on). OSM #6 stated that medical records file skin assessment sheets.

On 2/1/17 at 2:45 p.m., an interview was conducted with OSM #3, medical records. OSM #3 stated it has been awhile since she has filed weekly skin assessment sheets. OSM #3 stated that the unit secretary was responsible for filing weekly skin assessment sheets. OSM #3 stated that the weekly skin assessment sheets are pulled from the blue binder and put into the resident's clinical record. OSM #3 stated that she checks clinical records monthly to ensure accuracy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 45 On 2/1/17 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. A policy could not be presented regarding maintaining an accurate clinical record. No further information was presented prior to exit. 2. The facility staff failed to maintain an accurate clinical record for Resident #10. Resident #10's clinical record contained both a signed DDNR (Durable Do Not Resuscitate) order, and an order for a FULL CODE on the most recent POS (Physician Order Sheet) dated 1/4/17. Resident #10 was admitted to the facility on 3/5/15 with diagnoses that included but were not limited to high blood pressure, cirrhosis of the liver, osteoporosis, mild intellectual difficulties and history of falls. Resident #10's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/22/16. Resident #10 was coded as being cognitively intact in the ability to make daily decisions scoring 11 out of 12 on the BIMS (Brief Interview for Mental Status) exam. Resident #10 was coded as requiring limited assistance from one staff member with transfers, locomotion, dressing, eating, toileting, and personal hygiene; and total dependence on staff with bathing. Review of Resident #10's clinical record revealed a sticker on the front of the binder that documented, "DNR" (Do Not Resuscitate). This sticker had the Resident's name (Resident #10) written on it.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 46 Further review of the clinical record revealed a "Durable Do Not Resuscitate Order" dated 3/5/15, which documented the following: "I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above (Resident #10). I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify...2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment because he/she is unable to determine the nature, extent, or probable consequence of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision...I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation, and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct personnel to provide the patient other medical interventions, such as fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain." This from was signed by the POA (power of attorney). Review of Resident #10's most recent POS (Physician Order Sheet) signed by the physician on 1/4/17 documented the following order: "CODE STATUS; FULL CODE." This order was initiated on 3-5-15.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 47 On 2/1/17 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked where she looks to identify a resident's code status, LPN #3 pointed to the sticker on the inside of the chart and stated, "The code status is in the front of the chart." On 2/2/17 at 8:55 a.m., an interview was conducted with LPN #5 and LPN #4. When asked about the process staff follows for determining a resident's code status, LPN #5 stated that upon admission a resident's code status is determined by the code status they had in the hospital. LPN #5 also stated that admissions will ask the resident or responsible party about advanced directive preferences. LPN #5 stated that the advanced directive form is in the resident's admission packet. LPN #4 stated that if a resident wishes to be a DNR (Do Not Resuscitate), that the physician will be made aware and two nurses will sign the DNR form along with the responsible party. From there, an order is written and the doctor will sign the order and form when he/she comes into the facility. The advanced directive form along with a sticker documenting code status is then placed in the clinical record. When asked about the process staff follows if a resident wishes to change their code status, LPN #5 stated that advanced directives are discussed in every care plan meeting and if the resident or RP (responsible party) wishes to change their directives, the same process is followed. LPN #5 stated that the social worker will call families or speak with the resident yearly to discuss advanced directives if these families or residents do not attend care plan meetings. LPN #5 stated that advanced directives are also discussed with the family or	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 48	F 514		

resident by the physician if the resident is having a decline in health condition. LPN #5 stated the sticker, advanced directive form and order should all match.

On 2/2/17 at 9:16 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked about the process staff follows for determining residents' advanced directives, ASM #2 stated that the code status is determined by the code status they had in the hospital. ASM #2 stated that if the resident does not come to the facility with a code status, the resident will automatically become a Full Code. The facility will then get in touch with the family or resident to determine their advanced directive preferences. ASM #2 stated that two nurses have to witness and sign a verbal order for the resident's advanced directive preference. ASM #2 stated that the physician will then come in and sign the physician's orders for DNR or Full Code and the DNR form if the resident chooses to be a DNR. ASM #2 stated that if they family or resident cannot decide advanced directive preferences, nursing staff and the physician will educate the resident and family about their options. When asked how the facility ensures accuracy of advanced directive preferences, ASM #2 stated the medical records will do periodic checks of the clinical records to ensure accuracy of advanced directives. ASM #2 stated the medical records ensure advanced directives match the physician's orders. ASM #2 then confirmed that Resident #10's advanced directives did not match his physician orders. When asked if Resident 10 was supposed to be a DNR or Full Code, ASM #2 stated that she thought he was supposed to be a DNR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 49 On 2/2/17 at 9:24 a.m., an interview was conducted with OSM (other staff member) #3, medical records. OSM #3 stated that she checks all resident's charts on a monthly basis for accuracy of advanced directives. OSM #3 also stated that she checks accuracy of advanced directives when the resident is admitted and as needed. OSM #3 stated that she ensures the sticker on the clinical record matches with the advanced directive form and physician's order. OSM #3 stated that if there is a discrepancy, she will notify the unit manager. OSM #3 stated that she did not notice that Resident #10's advanced directives did not match his physician's orders. On 2/2/17 at 9:16 a.m., ASM #2 was made aware of the above concern. No further information was presented prior to exit. 3. The facility staff failed to maintain an accurate clinical record for Resident #3. Resident #3's clinical record contained advanced directives to be both a FULL CODE and DNR, and she had an order to be a FULL CODE on her most recent POS dated 1/2/17. Resident #3 was admitted to the facility on 8/6/15 with diagnoses that included but were not limited to high blood pressure, diabetes, high cholesterol, stroke, hemiplegia (one sided paralysis), depression, chronic kidney disease, anxiety disorder and auditory/visual hallucinations. Resident #3's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/13/16. Resident #3 was coded as being cognitively intact	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 50	F 514		

in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance from two or more staff members with transfers, dressing, eating, toileting, and personal hygiene; and totally dependent on staff with locomotion and bathing.

Review of Resident #3's clinical record revealed a sticker on the front of the binder that documented, "DNR" (Do Not Resuscitate). This sticker had the Resident's name (Resident #3) written on it.

Further review of the clinical record revealed a "Durable Do Not Resuscitate Order" dated 9/16/05, which documented the following: "I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above (Resident #3). I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify...1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment...I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation, and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct personnel to provide the patient other medical interventions, such as fluids, oxygen, or other therapies deemed necessary to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 51	F 514		

provide comfort care or alleviate pain." This from was signed by Resident #3.

Review of the clinical record also revealed an "Emergency Response Directive" for Resident #3. The following was documented, "Resuscitation: I understand if my heart stops or my breathing stops, cardiopulmonary resuscitation (CPR) will be attempted, with emergency transportation to the hospital where full life support measures may be undertaken. This form was signed by the resident on 8/12/15 documenting that she wanted Resuscitate.

Review of Resident #3's POS (Physician Order Sheet) dated 1/2/17 documented the following order: "CODE STATUS; FULL CODE." This order was initiated on 8/13/15.

On 2/1/17 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked where she looks to identify a resident's code status, LPN #3 pointed to the sticker on the inside of the chart and stated, "The code status is in the front of the chart."

On 2/2/17 at 8:55 a.m., an interview was conducted with LPN #5 and LPN #4. When asked about the process staff follows for determining a resident's code status, LPN #5 stated that upon admission a resident's code status is determined by the code status they had in the hospital. LPN #5 also stated that admissions will ask the resident or responsible party about advanced directive preferences. LPN #5 stated that the advanced directive form is in the resident's admission packet. LPN #4 stated that if a resident wishes to be a DNR (Do Not Resuscitate), that the physician will be made

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 52	F 514		

aware and two nurses will sign the DNR form along with the responsible party. From there, an order is written and the doctor will sign the order and form when he/she comes into the facility. The advanced directive form along with a sticker documenting code status is then placed in the clinical record. When asked about the process staff follows if a resident wishes to change their code status, LPN #5 stated that advanced directives are discussed in every care plan meeting and if the resident or RP (responsible party) wishes to change their directives, the same process is followed. LPN #5 stated that the social worker will call families or speak with the resident yearly to discuss advanced directives if these families or residents do not attend care plan meetings. LPN #5 stated that advanced directives are also discussed with the family or resident by the physician if the resident is having a decline in health condition. LPN #5 stated the sticker, advanced directive form and order should all match.

On 2/2/17 at 9:16 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked about the process staff follows for determining residents' advanced directives, ASM #2 stated that the code status is determined by the code status they had in the hospital. ASM #2 stated that if the resident does not come to the facility with a code status, the resident will automatically become a Full Code. The facility will then get in touch with the family or resident to determine their advanced directive preferences. ASM #2 stated that two nurses have to witness and sign a verbal order for the resident's advanced directive preference. ASM #2 stated that the physician will then come in and sign the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 53	F 514		

physician's orders for DNR or Full Code and the DNR form if the resident chooses to be a DNR. ASM #2 stated that if they family or resident cannot decide advanced directive preferences, nursing staff and the physician will educate the resident and family about their options. When asked how the facility ensures accuracy of advanced directive preferences, ASM #2 stated the medical records will do periodic checks of the clinical records to ensure accuracy of advanced directives. ASM #2 stated the medical records ensure advanced directives match the physician's orders. ASM #2 then confirmed that Resident #3's advanced directives did not match his physician orders.

On 2/2/17 at 9:24 a.m., an interview was conducted with OSM (other staff member) #3, medical records. OSM #3 stated that she checks all resident's charts on a monthly basis for accuracy of advanced directives. OSM #3 also stated that she checks accuracy of advanced directives when the resident is admitted and as needed. OSM #3 stated that she ensures the sticker on the clinical record matches with the advanced directive form and physician's order. OSM #3 stated that if there is a discrepancy, she will notify the unit manager. OSM #3 stated that she did not notice that Resident #3's advanced directives did not match his physician's orders. When asked if Resident #3 was a DNR or Full Code, OSM #3 stated, "I really don't know."

No further information was presented prior to exit.

4. Resident #2's clinical record failed to accurately reflect the resident's code status. Resident # 2's clinical record contained a DDNR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 54	F 514		

(Durable Do Not Resuscitate Order) dated 10/19/16, signed by the physician and RP (responsible party) in the clinical record and the most recent POS (physician order sheet) dated 01/04/17 documented, "Code Status: Full Code."

Resident # 2 was admitted to the facility on 10/18/16 with diagnoses that included but not limited to: anemia (1), hypothyroidism (2), urinary tract infection (3), dementia (4), anxiety (5), Meniere's disease (6), heart failure and depression.

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/12/17 coded Resident # 2 coded the resident as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 being moderately impaired of cognition. Resident # 2 was coded as requiring extensive assistance of one staff member for activities of daily living.

Review of Resident # 2's clinical record on 1/31/17 at 2:30 p.m. revealed a red sticker that documented DNR (Do Not Resuscitate) on the inside cover of the clinical record. Further review of the clinical record revealed a "DDNR (Durable Do Not Resuscitate Order)" for Resident # 2 dated 10/19/16 and signed by the physician and Resident # 2's responsible party.

The POS (physician order sheet) for Resident # 2 dated 01/04/17 documented, "Code Status: Full Code."

On 01/31/17 at 2:55 p.m. an interview was conducted with LPN (licensed practical nurse) # 3. When asked how they know a resident's code

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 55	F 514		

status LPN # 3 stated, "It's on the inside of the chart, it's a sticker

On 01/31/17 at 3:30 p.m. an interview was conducted with LPN # 4. When asked about the process of establishing a resident's code status, LPN # 4 stated, "If they come in from the hospital we follow that code status unless the physician or family requests something else. If they do the physician will speak with the family about the code status and write an order. If they come in without a code status, they are automatically a full code unless the family wants it changed. If they want a DNR two nurses will verify the code status with the family by each of the nurses speaking with the family at separate times."

On 02/02/17 at 9:16 a.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked about the process of establishing a resident's code status ASM # 2 stated, 'Sometimes the code status comes from the hospital. If they come in without a code status, they are automatically a full code unless the family wants it changed. If they want a DNR two nurses will verify the code status with the family by each of the nurses speaking with the family at separate times." When asked who ensures the accuracy of the resident's code status, ASM # 2 stated, "Medical records do a check to make sure the chart is accurate for the code status." ASM # 2 was asked to review Resident # 2's clinical record. After reviewing the inside cover of the clinical record, Resident #2's DDNR and POS, ASM # 2 was asked if the record was accurate. ASM # 2 stated, "No."

On 02/02/17 at 9:24 a.m. an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 56	F 514		

conducted with OSM # 3, director of medical records. When asked how often the resident's clinical record is reviewed for accuracy, OSM # 3 stated, "Monthly and any time it needs to be done. After reviewing the inside cover of the clinical record, Residents #2's DDNR and POS, OSM # 3 was asked if the record was accurate. OSM # 3 stated, "No."

On 02/01/17 at 4:45 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings.

No further information was obtained prior to exit.

References:
(1) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(2) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.

(3) An infection in the urinary tract. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm.

(4) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 57 (5) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (6) An inner ear disorder that affects balance and hearing. This information was obtained from the website: https://medlineplus.gov/ency/article/000702.htm.	F 514		