STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

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THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 8/29/17 through 8/31/17 . Four complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 108 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents # 1 through 19) and six closed record reviews (Residents # 20 through 25).	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157		10/6/17

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

Electronically Signed | 09/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to promptly notify the physician of a change in condition for one of 25 residents in the survey sample. Resident #5's physician was not promptly notified of newly acquired pressure sores and failed to notify the physician when the pressure sores deteriorated from a stage II status to stage III. The findings include: Resident #5 was admitted to the facility on 7/22/13 with diagnoses that included high blood	F 157	Resident #5□s physician was notified of the newly acquired pressure ulcer and deterioration in stages on 9/19/17. All residents with pressure ulcers have the potential to be affected by this practice. All current residents with pressure ulcers will be audited for physician notification of newly acquired pressure ulcers and deterioration in stages. Any variances will be corrected and education will be provided.	

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F 157	Continued From page 2 pressure, diabetes, benign prostatic hypertrophy with obstructive uropathy and depression. The minimum data set (MDS) dated 7/25/17 assessed Resident #5 with short and long-term memory loss and moderately impaired cognitive skills. Resident #5's clinical record documented the resident was assessed on 7/6/17 with blanchable redness on the resident's groin area and buttocks. This assessment documented the resident had excoriated skin measuring 4 cm (centimeters) x 4 cm x 0.2 cm (length x width x depth) with scant amount of drainage on the buttocks and upper thigh areas. A nursing note dated 7/12/17 stated the resident "...continues with blanchable skin to groin, and, buttocks with excoriated sites to coccyx...buttocks...Treatment already in place..." The record documented a physician's order dated 7/13/17 for cleansing, medi-honey application with a non-adhering dressing to be applied each day and as needed for the excoriated skin. In addition there was an ongoing physician's order (dated 10/17/16) for stomahesive protective powder to be applied topically to open wounds on the buttocks/testicles along with protective cream. A pressure ulcer record dated 7/25/17 documented the resident was assessed with a stage II pressure ulcer on his sacrum/coccyx area measuring 8 cm by 4 cm with no depth listed. This assessment listed the resident had "2 open areas" on the sacrum/coccyx area but documented measurement for only one pressure sore. There was no notification to the physician concerning the "2 open areas" or the assessment of a stage II pressure sore. An additional assessment on 7/29/17 documented the resident's sacrum/coccyx stage II pressure sore	F 157	The ADON/designee will educate all licensed nurses on timely physician notification of new pressure ulcers and changes in stages. The nurse administrative team will review residents with pressure ulcers 5x/week for 3 months during the administrative clinical meeting to ensure physician notification of changes in stages and newly acquired pressure ulcers. Any variances will be corrected and continued education provided. The DON will report results of the audit to the facilities QA committee for 3 months. Continued compliance will be monitored through the facilities Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns.	

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F 157	Continued From page 3	F 157		

measured 7.3 cm x 4.4 cm x 0.1 cm (length x width x depth) with scant drainage. A physician's order was obtained on 8/1/17 to discontinue the medi-honey treatment, start Diflucan 100 milligrams (mg) each day for 7 days and to apply Lotrimin cream over the groin/buttock area twice per day and sprinkle with Nystatin powder. The treatment records documented treatment and medication were administered as ordered.

An update to the sacrum/coccyx pressure sore record dated 8/5/17 listed the resident had a stage II ulcer measuring 7.0 cm x 5 cm x 0.2 cm with scant drainage. After this 8/5/17 assessment there was no further mention in the clinical record of the sacrum/coccyx stage II pressure sore. On 8/8/17 new pressure sore records were documented listing the following wounds: 1) Right buttocks stage III pressure sore measuring 1 cm x 3 cm x 0.3 cm with full thickness loss, red wound bed. 2) Right buttocks stage III pressure sore measuring 1.4 cm x 1.4 cm x 0.3 cm full thickness loss with red wound bed. 3) Left ischium stage II pressure sore measuring 0.6 cm x 0.8 cm x 0.2 cm open red area. 4) Crack between buttocks with excoriation measuring 2.4 cm x 0.2 cm x 0.2 cm. There was no notification to the physician concerning the stage III pressure sores or the newly assessed stage II pressure sore on the resident's left ischium. Nursing notes made no mention of the pressure sores or of any communication with the physician concerning the status of the resident's buttocks/ischium areas. The previous ordered treatments of Lotrimin cream, Nystatin powder and stomahesive powder for the buttocks/groin area continued.

The next assessment of the resident's buttocks

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F 157	Continued From page 4	F 157		

and ischium pressure sores was ten days later on 8/18/17. The pressures sores were assessed on 8/18/17 as follows: Right buttocks stage III pressure sore measuring .9 cm x 2.6 cm x 0.2 cm with no drainage; Right buttocks stage III pressure sore measuring 1.6 cm x 1.3 cm x 0.2 cm with scant drainage; Left ischium stage II pressure sore measuring 1.0 cm x 1.0 cm x 0.1 cm with no drainage; Crack between buttocks with excoriation measuring 2.0 cm x 0.4 cm x 0.1 cm.

As of 8/29/17 at 4:00 p.m. the clinical record documented no further assessments of Resident #22's pressure sores. The last assessment was eleven days prior on 8/18/17.

On 8/30/17 at 1:30 p.m. accompanied by the registered nurse unit manager (RN #3), Resident #5's buttocks/ischium wounds were observed. The resident's buttocks area was red with excoriation present on both buttock cheeks and the scrotum. There were small pinpoint sized open areas scattered across both buttock cheeks. This included a small open area over the left ischium and two small open areas on the right buttocks. There was a small linear open area between the cheeks in the coccyx area.

On 8/30/17 at 1:45 p.m. the registered nurse unit manager (RN #3) was interviewed about any notification to Resident #5's physician about pressure sore development and changes in the condition of the wounds assessed on 8/8/17. RN #3 stated he started working at the facility in August 2017 and he saw the "2 open areas" assessed on 7/25/17 with only one pressure sore listed with measurements so he wanted to re-assess the wounds. RN #3 stated he and

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F 157	Continued From page 5	F 157		

licensed practical nurse (LPN) #7 re-assessed Resident #5's buttocks/coccyx areas on 8/8/17 and identified the stage III pressure sores on the buttocks and the stage II pressure sore on the ischium. RN #3 stated LPN #7 was supposed to notify the physician. RN #3 stated he would look for any documentation concerning notification. RN #3 stated all of the resident's buttock/ischium wounds were improved today (8/30/17) as compared to his previous assessment on 8/8/17.

On 8/30/17 at 4:50 p.m. RN #3 stated he did not find any notification to the physician about Resident #5's pressure sores or change in wound status. RN #3 stated nurses were supposed to document any notifications in the nursing notes. RN #3 stated pressure ulcers and wounds were supposed to be assessed each week and include measurements. RN #3 stated pressure sore assessments were supposed to be documented on the pressure ulcer tracking form.

Resident #5's care plan (revised 8/29/17) listed the resident had excoriation to his groin, buttocks and sacrum in addition to new pressure wounds on his right buttock and left ischium. Interventions listed to promote healing and prevent further skin breakdown included, "Conduct weekly head to toe skin assessments and report abnormal findings to physician and chart in nurses notes...Observed for signs of infection...and report to physician..."

The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure injury as, "localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be

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F 157	Continued From page 6 painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear." The NPUAP defines a stage II pressure injury as, "Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible..." The NPUAP defines a stage III pressure injury as, "Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible..." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 8/30/17 at 2:00 p.m. (1) NPUAP Pressure Injury Stages. 2016. National Pressure Ulcer Advisory Panel. 9/1/17. www.npuap.org/	F 157		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph	F 226		10/6/17

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F 226	Continued From page 7 §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee file review, facility staff failed to implement their facility abuse policy for two of five employee records reviewed. Employee #2 was hired 1/11/17 and a criminal background check was not located in her employee file. Employee #3 was hired 10/27/16 and no sworn statement was located in her employee file. Findings included: On 08/31/17 at approximately 9:00 a.m., employee files were reviewed. A Virginia State Police criminal background check could not be located for Employee #2 with the hire date of 01/11/17. A sworn statement could not be	F 226	Employee #2□s criminal background check has been obtained and placed in the employee file. Employee # 3□s sworn statement has been obtained and placed in the employee file. All residents have the potential to be affected by this practice. The Payroll Coordinator will complete a 100% audit of employee files to ensure criminal background checks and sworn statements are obtained. Any variances will be corrected and continued education will be provided. The NHA will be educating all hiring managers on the required items to be	

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F 226	Continued From page 8 located for Employee #3 with the hire date of 10/27/16. The Business Office Manager (BOM) was interviewed at approximately 10:00 a.m. regarding the above findings. The BOM stated, "Let me go through their files and see if I can locate any of this missing information." At approximately 11:50 a.m. the BOM entered the conference room and stated, "I could not locate a criminal background check for this employee," referring to Employee #2. "She was rehired on 1/11/17, but another criminal background check was not obtained. The only background check I see is from 11/10/15." In reference to Employee #3, "She does not have a sworn statement in her employee file." A copy of the facility Abuse policy was requested and received by this surveyor on 08/31/17 at approximately 10:30 a.m. The policy, "Abuse Prohibition, Investigation, And Reporting" revised "11/16," included the following: "...Procedure: I. Prohibition: A. Screening: 1. The facility will screen prospective employees in order to not employ individuals who have been found guilty of abusing, neglecting, mistreating, or misappropriating property/resources of residents by a court of law, or who are listed in the state Nurse Aide Registry or professional licensing agency concerning the same and in accordance with individual state law requirements...e. In states where criminal background checks are conducted (Indiana, Michigan, North Carolina, Ohio, Virginia), the policy and procedure for these checks must be followed...2. A review of the applicant's past history must be considered prior to hiring and reasonable efforts must be made to uncover information about any past criminal	F 226	obtained for employee personnel records. The Payroll Coordinator will compete an audit of all newly hired employee records to ensure criminal background checks and sworn statements are obtained weekly x 3 months to ensure compliance. Any variances will be corrected and continued education will be provided. The Nursing Home Administrator will report results of the audits to the facilities QA committee for 3 months. Continued compliance will be monitored through the facilities quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

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F 226	Continued From page 9 history. 3. Signed consent will be obtained from each applicant before a conditional offer of employment can be made..." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 08/31/17 at approximately 12:30 p.m. No further information was obtained prior to the exit conference on 08/31/17.	F 226		
F 252 SS=D	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 252		10/6/17

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F 252	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to maintain a safe, homelike environment for one of 25 residents in the survey sample. Resident #11's over-bed table and the arm rest on her wheelchair were in disrepair. The findings include: Resident #11 was admitted to the facility on 3/19/12 with a re-admission on 1/16/15. Diagnoses for Resident #11 included Parkinson's disease, hypothyroidism, coronary artery disease, dementia and depression. The minimum data set (MDS) dated 8/11/17 assessed Resident #11 as cognitively intact. On 8/29/17 at 4:30 p.m. Resident #11 was in her wheelchair in her room. The covering on the left arm cushion on the resident's wheelchair was cracked with foam visible. The veneer covering on the resident's over-bed table was puckered around the edges of the table. The veneer was cracked near the center of the table. The corner of the over-bed table had missing veneer with particle board exposed. Resident #11 was interviewed about the condition of the table and arm cushion at the time of this observation. Resident #11 stated the over-bed table needed repair and had been cracked for "some time." The resident stated arm cushion was starting to crack. On 8/30/17 at 9:10 a.m. the licensed practical nurse (LPN #3) caring for Resident #11 was interviewed about the over-bed table and arm cushion. LPN #3 stated she would look at the	F 252	Resident # 11□s over-bed table and wheelchair arm rest were repaired on 8/30/17. All residents have the potential to be affected by this practice. The Maintenance Director will complete a 100% audit of all residents□ over-bed tables and wheelchairs to ensure are all in working order. Those found out of compliance will be repaired. The NHA will educate all department heads on prompt reporting of faulty equipment to the Maintenance Director for timely repair. The ADON/designee will educate all nursing staff on reporting of faulty equipment to the Maintenance Director for timely repair. The Maintenance Director will audit of 10% over-bed tables and wheelchairs needing repair weekly x 3 months to ensure equipment is safe and operable. Any variances will be corrected and continued education provided. The Maintenance Director will report results of the audits to the facilities QA committee for 3 months. Continued compliance will be monitored through the facilities Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns.	

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F 252	Continued From page 11 table and wheelchair cushion. LPN #3 stated she did not realize the table and arm cushion needed repair. LPN #3 stated work orders were entered with maintenance for equipment and room items needing repair. These findings were reviewed with the administrator and director of nursing during a meeting on 8/30/17 at 2:00 p.m.	F 252		
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 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	F 278		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 12 (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 the facility staff failed to ensure an accurate MDS (minimum data set) assessment for five of 25 residents in the survey sample: Resident # 2, # 10, # 13, # 17, and # 4. 1. Resident # 2's influenza information was entered incorrectly. 2. Resident # 10's influenza information was entered incorrectly. 3. Resident # 13's weight was entered incorrectly. 4. Resident # 17's cognitive information was blank. 5. Resident # 4 did not have the influenza vaccine date entered. Findings include: 1. Resident # 2's vaccination status was entered incorrectly on three MDS assessments after receipt of the influenza vaccine. Resident # 2 was admitted to the facility 4/11/17 with diagnoses to include, but not limited to: dementia, diabetes, high blood pressure, and emphysema.	F 278	Residents #2, #10, #13, #17 and #4□s MDS will be corrected by 9/25/2017. All residents have the potential to be affected by this practice. The Regional MDS nurse will audit all residents MDS to ensure weights are entered correctly and that flu and pneumonia vaccines are entered accurately along with cognitive status. Any variances will be modified or scheduled for corrected MDS. The Regional MDS Nurse will educate the MDS Coordinators on complete and accurate documentation in the MDS with a focus on accuracy of weights, vaccines and cognitive status. The Regional MDS Nurse/designee will audit of 10% of new resident MDS□s for accurate coding of the flu and pneumonia vaccines, weights, and cognitive status weekly x 3 months to ensure documentation is complete. Any variances will be modified or scheduled for corrected MDS and continued education will be provided. The DON will report results of the audits to the facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

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F 278	Continued From page 13 The most recent MDS (minimum data set) was a quarterly review dated 6/20/17. Resident # 2 was coded as having long term and short term memory problems, and moderate impairment in daily decision making skills. The clinical record was reviewed 8/29/17 at 1:00 p.m. The most recent full MDS, a significant change assessment dated 3/25/17 was also reviewed. Section O at part O0250A for influenza vaccine was coded as "0" indicating the resident had not received the influenza vaccine in the facility. The reason code at O0250B was left blank with no date entered for administration of the influenza vaccine. At O0250C for the reason the influenza vaccine was not received "5" was entered as the reason code indicating the vaccine had not been offered to the resident. Section O was then reviewed for MDS assessments dated 3/3/17 and 1/19/17. Those MDS assessments both indicated the influenza vaccine had not been received in the facility, and had been offered and declined with reason code "4" at O0250C. A review of the MAR (medication administration record) was then conducted, and revealed documentation the resident had received the influenza vaccine 12/8/16. The MDS assessments reviewed did not document a date for the administration of the resident's influenza vaccine. On 8/30/17 beginning at 1:55 p.m. during a meeting with facility staff, RN (registered nurse) # 2, who was the regional MDS coordinator, was asked who was responsible for coding Section O, and where that information was obtained. RN # 2 stated "The MDS nurse does that section except for the therapy part; the nurse also talks to the	F 278	QA committee for 3 months. Continued compliance will be monitored through the facilities Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns.	

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	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

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F 278	Continued From page 14	F 278		

administrative nurses for that information." RN # 2 was then asked if it was known who had done those MDS assessments which were incorrectly coded for the influenza vaccine for Resident # 2. RN # 2 stated "Well, there was a major turnover in staff, so a multitude of people were doing the assessments. I really don't know what to tell you; it's not known who did those at that time."

No further information was provided prior to the exit conference.

Pages O-7 and O-8 of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual states concerning assessment of administration of influenza vaccine: "Review the resident's medical record to 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..... Ask the resident if he or she received an influenza vaccine outside of the facility.....If the resident is unable to answer, then asked the same question of the responsible party/legal guardian and/or primary care physician.....if influenza vaccination status cannot be determined, administer the influenza vaccine to the resident..." Coding instructions for section O0250A directs "Code), no, if the resident did NOT receive the influenza vaccine in this facility during this year's influenza season....." Coding instructions for O0250B, Date influenza vaccine received instructs "Enter the date that the influenza vaccine was received. Do not leave any boxes blank." Coding instructions for O0250C, if the influenza vaccine was not received, state reason: "Code 1, Resident not in this facility during this year's influenza vaccination season.....Code 2: received outside this facility.....

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

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F 278	Continued From page 15	F 278		

Code 3: Not eligible- medical contraindication....Code 4: offered and declined.... Code 5: not offered..... Code 6: inability to obtain influenza vaccine due to a declared shortage.....Code 9: none of the above." (1).

(1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.14, Centers for Medicare & Medicaid Services, Revised October 2016.

2. Resident # 10's vaccination status was entered incorrectly on three MDS assessments after receipt of the influenza vaccine.

Resident # 10 was admitted to the facility 2/13/17 with diagnoses to include, but not limited to: muscle weakness, dementia, history of hip fracture, and low thyroid.

The most recent MDS (minimum data set) was a quarterly review dated 8/16/17. Resident # 10 was coded as having short term and long term memory problems, and severe impairment in daily decision making skills.

Resident # 10's clinical record was reviewed 8/29/17 at 1:30 p.m. The most recent full MDS, a significant change assessment dated 12/29/16 was also reviewed. Section O at part O0250A for influenza vaccine was coded as "0" indicating the resident had not received the influenza vaccine in the facility. The reason code at O0250B was left blank with no date entered for administration of the influenza vaccine. At O0250C for the reason the influenza vaccine was not received "2" was entered as the reason code indicating the resident had received the influenza vaccine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 278	Continued From page 16	F 278		

outside the facility. Section O was then reviewed for MDS assessments dated 10/11/16 and 2/27/17. Those MDS assessments both indicated the influenza vaccine had not been received in the facility. For the MDS assessment dated 2/27/17, the reason code for O0250C was coded "3", resident not eligible due to a medical contraindication. The MDS assessment dated 10/11/16 was coded for O0250C as "2", received outside the facility. A review of the MAR (medication administration record) was then conducted, and revealed documentation the resident had received the influenza vaccine 11/9/16. The MDS assessments reviewed did not document a date for the administration of the resident's influenza vaccine.

On 8/30/17 beginning at 1:55 p.m. during a meeting with facility staff, RN (registered nurse) # 2, who was the regional MDS coordinator, was asked who was responsible for coding Section O, and where that information was obtained. RN # 2 stated "The MDS nurse does that section except for the therapy part; the nurse also talks to the administrative nurses for that information." RN # 2 was then asked if it was known who had done those MDS assessments which were incorrectly coded for the influenza vaccine for Resident # 2. RN # 2 stated "Well, there was a major turnover in staff, so a multitude of people were doing the assessments. I really don't know what to tell you; it's not known who did those at that time."

No further information was provided prior to the exit conference.

Pages O-7 and O-8 of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual states concerning assessment of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 278	Continued From page 17	F 278		

administration of influenza vaccine: "Review the resident's medical record to 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..... Ask the resident if he or she received an influenza vaccine outside of the facility.....If the resident is unable to answer, then asked the same question of the responsible party/legal guardian and/or primary care physician.....if influenza vaccination status cannot be determined, administer the influenza vaccine to the resident..." Coding instructions for section O0250A directs "Code), no, if the resident did NOT receive the influenza vaccine in this facility during this year's influenza season....." Coding instructions for O0250B, Date influenza vaccine received instructs "Enter the date that the influenza vaccine was received. Do not leave any boxes blank." Coding instructions for O0250C, if the influenza vaccine was not received, state reason: "Code 1, Resident not in this facility during this year's influenza vaccination season.....Code 2: received outside this facility..... Code 3: Not eligible- medical contraindication.... Code 4: offered and declined.... Code 5: not offered..... Code 6: inability to obtain influenza vaccine due to a declared shortage.....Code 9: none of the above." (1).

(1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.14, Centers for Medicare & Medicaid Services, Revised October 2016.

3. The facility staff failed to ensure an accurate MDS (minimum data set) assessment for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

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F 278	Continued From page 18	F 278		

Resident 13 regarding weights; Resident # 13's weight was recorded on three MDS assessments as approximately 40 lbs greater than the resident's actual weight.

Findings include:

Resident # 13 was admitted to the facility on 12/02/16. Diagnoses for Resident # 13 included, but were not limited to: coronary artery disease, high blood pressure, enlarged prostate, muscle weakness, cerebellar stroke syndrome, malaise and hearing loss.

The most current full MDS assessment was the admission assessment dated 12/09/17. This MDS assessed the resident as having a cognitive score of 4, indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as being 68 inches tall and weighing 177 lbs (pounds) on this MDS.

The most current quarterly assessment dated 06/04/17, assessed the resident with a cognitive score of 9, indicating moderate impairment. The resident was assessed on this MDS as being 68 inches tall and weighing 132 lbs. A 43 lb pound weight difference between the two MDS assessments.

On 08/30/17 at approximately 1:40 p.m. the corporate MDS person was interviewed and asked for assistance in locating Resident # 13's weight records because the weight records were not listed in the electronic clinical record and could not be found on the resident's paper record. Concerns were expressed regarding the resident's weight discrepancy of 43 lbs between December 2016 and June 2017 MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 278	Continued From page 19 assessments. On 08/31/17 at approximately 11:45 a.m., the corporate MDS person presented the weight record for Resident # 13 from medical records, which evidenced that the resident was below IBW (ideal body weight) and originally weighed in the 130's upon admission in December of 2016. MDS was asked where the weight of 177 came from. The MDS person stated that it was not known where that weight was obtained from, but it was an error. The MDS person was made aware that Resident # 13's weight was incorrectly documented on the admission MDS assessment above, as well as the 14 day assessment dated 12/16/17 (178 lbs), the 30 day assessment dated 12/30/16 (174 lbs), and a quarterly assessment dated 03/07/16 (177 lbs). The administrator, DON (director of nursing) and corporate MDS person were made aware in a meeting with the survey team on 08/31/17 at noon. No further information and/or documentation was presented prior to the exit conference on 08/31/17. 4. The facility failed to ensure an accurate MDS for Resident # 17 in the area of cognition; the resident's current cognitive status (July 2017) assessed as a '15' compared to the resident's admission assessment (May 2017), where the cognitive assessment was left blank.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 278	Continued From page 20	F 278		

Findings include:

Resident # 17 was admitted to the facility on 05/05/17. Diagnoses for Resident # 17 included, but were not limited to: obstructive uropathy, diabetes mellitus, increased lipids, arthritis, and macular degeneration.

The most current full MDS was an admission assessment dated 05/16/17. The cognitive sections CO100. was marked as 'yes' to continue to CO200., this was blank. Sections CO300. through CO700. were all blank. Sections CO700., CO800. and CO900. were all marked '0', indicating no problems with memory/cognition.

The most current quarterly assessment dated 07/31/17 was reviewed and documented the resident as having a cognitive score of '15', indicating the resident was cognitively intact for daily decision making skills.

On 08/31/17 at approximately 11:40 a.m., the corporate MDS person was asked who is responsible for completing the cognitive section of the MDS. The MDS person stated that the SW (social worker) was responsible for that section.

The SW was asked shortly thereafter, why Resident # 17's cognitive section of his admission assessment was blank, where a score should be. The SW stated that she did not know, but stated she would look at it and find out.

At approximately 1:10 p.m., the SW stated that she (the SW) was on vacation that week and when she came back from vacation it was not done. The SW was asked who is responsible for completing this section if she is gone or on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 278	Continued From page 21 vacation. The SW did not specify who's responsibility it is while she is off or on vacation. The administrator and DON were made aware at approximately 1:30 p.m. No further information and/or documentation was presented prior to the exit conference. 5. Facility staff failed to code Resident #4's Quarterly MDS (minimum data set) with an ARD (assessment reference date) of 01/02/2017, Section O, O0250. Influenza Vaccine correctly. Resident #4 was originally admitted to the facility on 08/17/2005 and readmitted on 04/09/2017 with diagnoses including, but not limited to: Left Hip Fracture with ORIF (open reduction internal fixation), Diabetes, Hypertension, Alzheimer's Disease, Depression, Anxiety and Psychosis. The most recent MDS was a quarterly assessment with an ARD of 07/12/17. Resident #4 was assessed as severely impaired in her cognitive skills with a total cognitive score of three out of 15. Resident #4's clinical record was reviewed on 08/29/17 at 1:30 p.m. During this review a discrepancy was noted on her Immunization Record versus her Influenza Vaccine documented on her MDS. A quarterly MDS with an ARD of 01/02/2017 included the following: "...Section O...O0250. Influenza Vaccine...A. Did the resident receive the influenza vaccine in this facility for this year's influenza season? 0. No -	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 Skip to O0250C, If influenza vaccine not received, state reason 1. Yes - Continue to O0250B, Date influenza vaccine received." Code entered was "0. B. Date influenza vaccine received - Complete date and skip to O0300A...C. If influenza vaccine not received, state reason: ...5. Not offered..." Code entered was "5." On 08/30/17 at 11:25 a.m., RN #2 (registered nurse) was interviewed regarding Resident #4's Immunization Record and MDS. RN #2 stated, "Let me look at it and I will get back with you." At approximately 11:40 a.m., RN #2 entered the conference room and stated, "She [Resident #4] received the flu vaccine on 11/03/16. I found a copy of her Immunization Record in her thinned record located in medical records. Her MDS with the ARD of 01/02/17," Section O0250...A. 1..."should have been coded as yes with the date 11/03/2016." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 08/30/2017 at 2:00 p.m. No further information was received by the survey team prior to the exit conference on 08/31/2017.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request	F 280		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 280	Continued From page 23 revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 280	Continued From page 24 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to review and revise the CCP (comprehensive care plan) for two of 25 residents in the sample, Resident # 13 and Resident # 10 . 1. The facility failed to review and revise Resident # 13's CCP regarding hearing and hearing devices.	F 280	Resident # 13□s care plan was updated to include hearing loss and hearing devices. Resident # 10□s care card was updated to include current interventions to include wander bracelet. All residents have the potential to be affected by this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 280	Continued From page 25 2. The facility staff failed to update Resident # 10's Care Card to include current interventions in place for resident care. Findings include: 1. The facility failed to review and revise Resident # 13's CCP regarding hearing and hearing devices. Resident # 13 was admitted to the facility on 12/02/16. Diagnoses for Resident # 13 included, but were not limited to: coronary artery disease, high blood pressure, enlarged prostate, muscle weakness, cerebellar stroke syndrome, malaise and hearing loss. The most current full MDS assessment was the admission assessment dated 12/09/17. This MDS assessed the resident as having a cognitive score of 4, indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as having moderate difficulty hearing and as having a hearing aid. Resident # 13 was observed 08/30/17 at approximately 7:45 a.m., in the dining room on the resident's living unit. A brief interview was conducted with the resident. The resident was very hard of hearing and had great difficulty communicating due to the degree of hearing loss. This surveyor spoke to the resident in an extremely loud tone, almost yelling at times in an attempt to have the resident hear. Resident # 13's clinical record was reviewed. It was documented through out that the resident	F 280	The nurse administrative team will audit all residents with hearing loss to ensure Care Plans and Care Cards reflect accurate information regarding care and current interventions. Any variances will be corrected and continued education will be provided. The DON/designee will educate all licensed nursing staff on updating Care Plans and Care Cards to ensure they reflect current and accurate care provided. The nurse administrative team will complete a weekly audit of 10% of residents with hearing loss for 4 weeks to ensure Care Plans and Care Cards are current and accurate. Any variances will be corrected and continued education will be provided. The DON will report results of the audits to facilities QA committee for 4 weeks. Continued compliance will be monitored through the facilities 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
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 280	Continued From page 26	F 280		

was extremely HOH (hard of hearing).

Resident # 13's current physician's orders were reviewed. No orders were found and/or located on the physician's order sheet for hearing and/or communication.

The resident's CCP (comprehensive care plan) was then reviewed and documented, "...provide reality based information in a calm and patient manner...ensure supplies for independent activities are available HOH...mystery, other Pet therapy...ensure TV remote in reach...Guest unable to hear audio will read...give simple choices and give ample time to respond...ask yes/no questions..."

The CCP did not address any assistive devices, any techniques or interventions to help assist the resident in hearing to facilitate communication with the resident.

The resident was again observed and briefly interviewed on 08/31/17 at approximately 8:00 a.m., with the same results as above very difficult to hear with the communicator, almost yelling to help the resident hear the conversation.

On 08/31/17 at approximately 9:30 a.m., the SW (social worker) and the corporate MDS person were made aware of the above information regarding Resident # 13 and was asked if the resident had hearing aids.

At 10:00 a.m., the SW returned and stated that the resident had two hearing aids in his bedside table drawer. The SW stated that she had saw them yesterday. The SW was asked if they were identified on the resident's personal belongings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 280	Continued From page 27	F 280		

list and the SW stated, "No." The SW was informed that there was no documentation located in the resident's clinical record to evidence that the resident owned or had any hearing aids and/or devices of any type.

At approximately 10:05 a.m., this surveyor went directly to the resident's room on Unit 1. The resident was seated in his room in a high back wheelchair (w/c) with his back to his night stand, there was an audio recording playing behind the resident. The resident did not hear the knock on the door and did not hear the loud tone to announce a visitor; this surveyor entered the room slow and waved a hand in front of the resident before he realized anyone was there. The resident spoke and again could not hear what the surveyor was saying without the surveyor being right next to the ear and speaking in an extremely loud voice. The resident was asked about his hearing aids, the resident replied that he did not know where they were, he had not seem them in quite a while. The resident then stated, look in my drawer. The drawer was opened and there were two clear plastic bags inside. One bag had a 'pocket talker/amplifier' with a headphones and one bag had a traditional pair (2) hearing aids, with two AA batteries in the bag, as well. The resident was asked why did he not have them in, and the resident stated that he didn't know. The resident was asked if there was any reason he did not have them in. The resident stated, no and then stated to put them in. It was explained to the resident that this would be checked on with the nurse. This surveyor left the room and CNA (certified nursing assistant) # 7 was asked about the hearing devices in the plastic bag. The CNA stated that he (the resident) does not wear these (the bag with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 280	Continued From page 28	F 280		

traditional hearing aids) and went on to say that he wore the 'pocket box', "that's what he use." The CNA then stated that the 'pocket box' was broke and that is why the resident isn't using it. The CNA was asked what was wrong with it and how did she know it was broken. The CNA then stated that the amplifier was broke on it and that the son had that piece to the device. The CNA was then asked how long had it been broken. The CNA stated, "3 months." The CNA was then asked about the traditional devices and the CNA stated that she didn't know anything about those.

The two bags were then taken to the unit coordinator, known as LPN (Licensed Practical Nurse) # 5, by CNA # 7. The LPN stated that the resident was using the box, but did not know that the 'pocket box' was broken or how long it had been broken, the LPN further stated that she did not know that the resident had any other devices (traditional hearing aids) and did not know if anyone had checked them to see if they were operational or not; the LPN stated that she did not know that the (hearing aids) were in his drawer.

At approximately 10:30 a.m., the DON (director of nursing) and administrator were made aware of the above information.

At 11:03 a.m., the SW in the presence of the DON came to this surveyor and stated, "I just spoke with the son and the reason he [resident] doesn't wear the hearing aids is because the 'box' works better...the son said he is getting a new box." The SW and DON were asked, if anyone had checked the traditional hearing aids to see if they are operational; neither knew if they were operational or not. The SW was asked why it took this long to contact the son in regards to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 280	Continued From page 29	F 280		

'pocket box amplifier', since it was stated by CNA # 7 that this device had been broke for several months. The SW did not provide an explanation.

The administrator, DON, SW corporate nurse, and regional manager were all made aware in a meeting of the concerns regarding Resident # 13's hearing loss and the fact that the resident had two interventions to assist the resident with hearing and that neither were being used and/or had been maintained to prevent uninterruptible quality of care for the resident. The facility staff were also made aware that the resident's MDS assessments were incorrectly coded for hearing loss/hearing aids and the resident's CCP did not address Resident 13's specific issues regarding hearing loss such as interventions, assessments and/or goals.

No further information and/or documentation was presented prior to the exit conference on 08/31/17.

2. The facility staff failed to update Resident # 10's Care Card to include current interventions in place for resident care.

Resident # 10 was admitted to the facility 2/13/17 with diagnoses to include, but not limited to: muscle weakness, dementia, history of hip fracture, and low thyroid.

The most recent MDS (minimum data set) was a quarterly review dated 8/16/17. Resident # 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 280	Continued From page 30	F 280		

was coded as having short term and long term memory problems, and severe impairment in daily decision making skills.

Resident # 10's clinical record was reviewed 8/29/17 at 1:30 p.m. It was noted that Resident # 10 had a physician order for a wander bracelet. The care plan was then reviewed. The care plan included the intervention for a wander bracelet applied to Resident # 10's left ankle.

On 8/30/17 at 8:00 a.m. this surveyor went to Resident # 10's room. Resident # 10's roommate gave permission for this surveyor to enter and stated "She's [Resident # 10] still asleep." Resident # 10 was in bed with the covers up over her head. This surveyor opened the resident's closet door, and observed an empty plastic holder attached to the inside of the door. At that time, this surveyor went to the nurses' station where LPN (licensed practical nurse) # 5, the unit manager, was preparing to begin the medication administration. LPN # 5 was asked about the empty plastic holder in Resident # 10's closet door. LPN # 5 stated "Oh, that's where her care card goes; was it not there? I gave it to one of the CNA's (certified nursing assistant) to put in there yesterday afternoon." LPN # 5 then went to the desk and retrieved the care card for Resident # 10 stating "Here it is; I'm not sure why it wasn't in her room." This surveyor reviewed the care card information, which was dated 2/25/17 and did not include the wander bracelet intervention. LPN # 5 was asked how often the care card was updated, and would the wander bracelet be included on the care card? LPN # 5 stated she was not sure how often the care card was updated, but stated "It should have been."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 280	Continued From page 31 On 8/30/17 at 11:20 a.m. the regional MDS coordinator, identified as RN (registered nurse) # 2, was asked if there was a policy for updating care card information. RN # 2 stated "There's not a policy; the expectation is the care card should be updated when the care plan meeting for the resident is held to include any new orders or interventions." RN # 2 was then asked who was responsible to update the care cards. RN # 2 stated "The unit managers or the MDS nurse does the updates." On 8/30/17 during a meeting with facility staff beginning at 1:55 p.m. the administrator, DON (director of nursing), and regional staff were informed of the above findings. On 8/31/17 at 7:50 a.m. the administrator presented this surveyor with a copy of the updated care card dated 8/30/17. No further information was provided prior to the exit conference.	F 280		
F 313 SS=E	483.25(a)(1)(2) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION (a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the	F 313		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 313	Continued From page 32 provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review the facility staff failed to ensure proper treatment and assistive devices to maintain hearing ability for one of 25 residents in the survey sample, Resident # 13. The facility staff failed ensure Resident # 13's hearing assistive devices were utilized and failed to ensure that the devices were operational and/or maintained good working order to assist the resident with severe hearing impairment for several months. Findings include: Resident # 13 was admitted to the facility on 12/02/16. Diagnoses for Resident # 13 included, but were not limited to: coronary artery disease, high blood pressure, enlarged prostate, muscle weakness, cerebellar stroke syndrome, malaise and hearing loss. The most current full MDS assessment was the admission assessment dated 12/09/17. This MDS assessed the resident as having a cognitive score of 4, indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as having moderate difficulty hearing and as having a hearing aid. Resident # 13 was observed 08/30/17 at approximately 7:45 a.m., in the dining room on the resident's living unit. A brief interview was conducted with the resident. The resident was	F 313	Resident # 13□s hearing device was repaired. All residents who are hearing devices have the potential to be affected by this practice. The administrative nursing team will review all new admissions and current residents who are hearing impaired to ensure hearing/assistive devices are being utilized per physician order and are functioning properly. Any variances will be corrected and continued education will be provided. The DON/designee will educate all nursing staff on ensuring hearing devices are utilized and in functioning properly. The nurse administrative team will complete a weekly audit of 10% of residents who are hearing impaired for 4 weeks to ensure devices are utilized and functioning properly. Any variances will be corrected and continued education will be provided. The DON will report the results of the audits to the facilities QA committee for 4 weeks. Continued compliance will be monitored through the facilities 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
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 313	Continued From page 33	F 313		

very hard of hearing and had great difficulty communicating due to the degree of hearing loss. This surveyor spoke to the resident in an extremely loud tone, almost yelling at times in an attempt to have the resident hear. The resident was asked if he had hearing aids. The resident responded that he did have an expensive pair ($7,000.00) of hearing aids that he thought were lost while received a shower/bath. The resident could not remember when the last time he had seen the hearing aids, but stated, "It has been quite some time."

Resident # 13's clinical record was reviewed. It was documented through out that the resident was extremely HOH (hard of hearing).

Resident # 13's current physician's orders were reviewed. No orders were found and/or located on the physician's order sheet for hearing and/or communication.

The resident's CCP (comprehensive care plan) was then reviewed and documented, "...provide reality based information in a calm and patient manner...ensure supplies for independent activities are available HOH...mystery, other Pet therapy...ensure TV remote in reach...Guest unable to hear audio will read...give simple choices and give ample time to respond...ask yes/no questions..."

The CCP did not address any assistive devices, any techniques or interventions to help assist the resident in hearing to facilitate communication with the resident.

The resident was again observed and briefly interviewed on 08/31/17 at approximately 8:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 313	Continued From page 34	F 313		

a.m., in the dining room of his living unit. The interview was the same as the day before, in that the resident had great difficulty hearing with the conversation.

On 08/31/17 at approximately 9:30 a.m., the SW (social worker) and the corporate MDS person were made aware of the above information regarding Resident # 13 and was asked if the resident had hearing aids.

At 10:00 a.m., the SW returned and stated that the resident had two hearing aids in his bedside table drawer. The SW stated that she had saw them yesterday. The SW was asked if they were identified on the resident's personal belongings list and the SW stated, "No." The SW was informed that there was no documentation located in the resident's clinical record to evidence that the resident owned or had any hearing aids and/or devices of any type.

At approximately 10:05 a.m., this surveyor went directly to the resident's room on Unit 1. The resident was seated in his room in a high back wheelchair (w/c) with his back to his night stand, there was an audio recording playing behind the resident. The resident did not hear the knock on the door and did not hear the loud tone to announce a visitor; this surveyor entered the room slow and waved a hand in front of the resident before he realized anyone was there. The resident spoke and again could out what the surveyor was saying without the surveyor being right next to the ear and speaking in an extremely loud voice. The resident was asked about his hearing aids again, the resident replied that he did not know where they were, and again stated that it had been a long time, since he had seen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 313	Continued From page 35	F 313		

them. The resident was informed that the SW had stated that she seen them in his night stand. The resident then stated, "Look in my drawer." The drawer was opened and there were two clear plastic zip lock bags inside. One zip bag had a 'pocket talker/amplifier' with a headphone set. The other zip bag had a traditional pair (2) hearing aids, along with two AA batteries. The resident was asked why did he not have them in, and the resident stated that he didn't know. The resident was asked if there was any reason he did not have them in or he did not want to wear them. The resident stated, "No, put them in." The resident was informed that this surveyor was going to speak with the nurse to find out further information regarding the hearing devices in both bags. This surveyor left the resident's room and CNA (certified nursing assistant) # 7 just outside the resident's room and was asked about the hearing devices in the plastic bags. The CNA stated that he (the resident) does not wear these (the bag with the traditional hearing aids) and went on to say that he wore the 'pocket box', and held up the bag with the pocket box and stated, "That what he use [sic]." The CNA then stated that the 'pocket box' was broke and that is why the resident isn't using it. The CNA was asked what was wrong with it and how did she know it was broken. The CNA pointed to the device and then stated that the amplifier was broke on it and that the son had that piece to the device. The CNA did not know the what caused the device to break. The CNA was then asked how long had it been broken. The CNA stated, "3 months." The CNA was then asked about the traditional devices and the CNA stated, "Oh, I don't know anything about those."

The two bags were then taken to the unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 313	Continued From page 36	F 313		

coordinator, known as LPN (Licensed Practical Nurse) # 5, by CNA # 7. The LPN stated that the resident was using the box, but did not know that the 'pocket box' was broken or how long it had been broken, the LPN further stated that she did not know that the resident had any other devices (traditional hearing aids) and did not know if anyone had checked them to see if they were operational or not; the LPN stated that she did not know that the (hearing aids) were in his drawer.

At approximately 10:30 a.m., the DON (director of nursing) and administrator were made aware of the above information.

At 11:03 a.m., LPN # 5 in the presence of the DON came to this surveyor and stated, "I just spoke with the son and the reason he [resident] doesn't wear the hearing aids is because the 'box' works better...the son said he is getting a new box." The LPN and DON were asked, if anyone had checked the traditional hearing aids to see if they are operational; neither knew if they were operational or not. The LPN was asked why it took this long to contact the son in regards to the 'pocket box amplifier', since it was stated by CNA # 7 that this device had been broke for several months. No explanation was provided.

The administrator, DON, SW corporate nurse, and regional manager were all made aware in a meeting of the concerns regarding Resident # 13's hearing loss and the fact that the resident had two interventions to assist the resident with hearing and that neither were being used and/or had been maintained to prevent uninterruptible quality of care for the resident. The facility staff were also made aware that the devices were not documented anywhere in the clinical record, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 313	Continued From page 37 was nearly nonexistent according to documentation. The facility staff were also made aware that the resident's MDS assessments were incorrectly coded for hearing loss/hearing aids and the resident's CCP did not address Resident 13's specific issues regarding hearing loss such as interventions, assessments and/or goals. No further information and/or documentation was presented prior to the exit conference on 08/31/17.	F 313		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure physician ordered devices were in place for the prevention of pressure ulcers, for one of 25 residents, Resident #7 and failed to provide	F 314	Resident # 7□s heels were floated immediately and Care Card placed in correct closet. Resident #5□s skin assessment was updated during the survey.	10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 314	Continued From page 38 ongoing pressure ulcer assessments for one of 25 residents, Resident #5. 1. Resident #7 did not have her heels floated while in bed on 08/29/2017. 2. The facility staff did not do weekly skin assessments of pressure ulcers for Resident #5. Findings were: 1. Resident #7 was admitted to the facility on 10/13/2011. Her diagnoses included, but were not limited to: Dysphagia, cerebral vascular accident (stroke) hypertension and right sided weakness. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/25/2017. Resident #7 was assessed as having a cognitive summary score of "08"; indicating moderate impairment with her cognitive status. On 08/29/2017 at approximately 2:20 p.m., Resident #7 was observed lying on her bed. She was covered up and her eyes were closed. Her legs/feet did not appear to be elevated off of the bed. This surveyor went to the nurse's station to see who the CNA (certified nursing assistant) for Resident #7 was. A staff person at the desk stated that the CNA assigned to Resident #7 was on break, but she was being cared for by CNA # 2. This surveyor found CNA # 2 and asked her if Resident #7's heels were floated (off of the bed). She went to the room and uncovered the	F 314	All residents have the potential to be affected by this practice. The nurse administrative team will complete a 100% audit of all residents with orders to float heels to ensure heels are floated as ordered and that weekly skin assessments for pressure ulcers are completed timely. Any variances will be corrected and continued education will be provided. The ADON/designee will educate all licensed nursing staff on pressure ulcer prevention to include assessment, documentation and implementing interventions and placement of care cards in facility closets. The nurse administration team will review 5x/week all new admissions and current residents to ensure skin assessments are completed. The nurse administration team will complete an audit 3x/week for 4 weeks all residents with orders to float heels to ensure interventions are applied per physician orders. Any variances will be corrected and continued education will be provided. The DON will report the results of the audits to the facilities QA committee for 4 weeks. Continued compliance will be monitored through the facilities 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
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 314	Continued From page 39	F 314		

resident. Resident #7's heels were not floated and were resting on the mattress. CNA # 2 stated, "I didn't get her in bed...I didn't know her heels were suppose to be up...I don't see one of those blue things [heelz up pad]...I'll get something."

While CNA # 2 was looking for something to elevate Resident #7's heels with, CNA # 3 returned from break. She was asked about Resident #7's heels. She stated, "Are they suppose to be floated?" CNA # 3 was asked if she had know that. She stated, "No." She was asked if Resident #7 had a Kardex care plan for the CNAs to follow. She stated, "Yes, it's in her closet." CNA # 3 and this surveyor looked at the Kardex. "Float heels was checked as an intervention for the CNAs to follow." CNA # 3 stated, "I see that, I'll take care of it."

As this surveyor was taking the Kardex to the nurse's station for a copy, it was noted that the Kardex did not have Resident #7's name on it, but the name of a resident in the room next door. The Kardex was returned to Resident #7's room and shown to CNA # 3. She sated, "Oh I see that...we don't put them in here, I didn't notice that."

The unit manager was approached about the Kardex. He stated, "I update them and put them in the room...yes, that's a problem if the wrong one was in there." He then obtained Resident #7's actual Kardex from a book. He stated, "Float heels is checked on this one too...I'll take care of it."

At approximately 2:45 p.m., this surveyor asked the DON (director of nursing) if the heels of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 314	Continued From page 40	F 314		

Resident #7 could be observed. She and this surveyor went to Resident #7's room. The DON removed the bilateral TED hose that Resident #7 was wearing. There was no skin impairment assessed on Resident #7's heels.

The above information was discussed during an end of day meeting on 08/30/2017 with the facility administrator, DON and corporate consultants.

No further information was obtained prior to the exit conference on 08/31/2017.

2. Facility staff failed to provide ongoing assessment and monitoring of Resident #5's pressure ulcers and failed to initiate changes in treatment when the pressure sore assessments indicated a decline in status.

Resident #5 was admitted to the facility on 7/22/13 with diagnoses that included high blood pressure, diabetes, benign prostatic hypertrophy with obstructive uropathy and depression. The minimum data set (MDS) dated 7/25/17 assessed Resident #5 with short and long-term memory loss and moderately impaired cognitive skills.

Resident #5's clinical record documented the resident was assessed on 7/6/17 with blanchable redness on the resident's groin area and buttocks. This assessment documented the resident had excoriated skin measuring 4 cm (centimeters) x 4 cm x 0.2 cm (length x width x depth) with scant amount of drainage on the buttocks and upper thigh areas. A nursing note dated 7/12/17 stated the resident "...continues

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 314	Continued From page 41	F 314		

with blanchable skin to groin, and, buttocks with excoriated sites to coccyx...buttocks... Treatment already in place..." The record documented a physician's order dated 7/13/17 for cleansing, medi-honey application with a non-adhering dressing to be applied each day and as needed for the excoriated skin. In addition there was an ongoing physician's order (dated 10/17/16) for stomahesive protective powder to be applied topically to open wounds on the buttocks/testicles along with protective cream.

A pressure ulcer record dated 7/25/17 documented the resident was assessed with a stage II pressure ulcer on his sacrum/coccyx area measuring 8 cm by 4 cm with no depth listed. This assessment listed the resident had "2 open areas" on the sacrum/coccyx area but documented measurements for only one pressure sore. There was no notification to the physician concerning the "2 open areas" or the assessment of a stage II pressure sore. An additional assessment on 7/29/17 documented the resident's sacrum/coccyx stage II pressure sore measured 7.3 cm x 4.4 cm x 0.1 cm (length x width x depth) with scant drainage. A physician's order was obtained on 8/1/17 to discontinue the medi-honey treatment, start Diflucan 100 milligrams (mg) each day for 7 days and to apply Lotrimin cream over the groin/buttock area twice per day and sprinkle with Nystatin powder. The treatment records documented treatment and medication were administered as ordered.

An update to the sacrum/coccyx pressure sore record dated 8/5/17 listed the resident had a stage II ulcer measuring 7.0 cm x 5 cm x 0.2 cm with scant drainage. After this 8/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 314	Continued From page 42	F 314		

assessment there was no further mention in the clinical record of the sacrum/coccyx stage II pressure sore. On 8/8/17 new pressure sore records were documented listing the following wounds: 1) Right buttocks stage III pressure sore measuring 1 cm x 3 cm x0 .3 cm with full thickness loss, red wound bed. 2) Right buttocks stage III pressure sore measuring 1.4 cm x 1.4 cm x 0.3 cm full thickness loss with red wound bed. 3) Left ischium stage II pressure sore measuring 0.6 cm x 0.8 cm x 0.2 cm open red area. 4) Crack between buttocks with excoriation measuring 2.4 cm x .2 cm x 0.2 cm. There was no notification to the physician concerning the stage III pressure sores or the newly assessed stage II pressure sore on the resident's left ischium. Nursing notes made no mention of the pressure sores or of any communication with the physician concerning the status of the resident's buttocks/ischium areas. The previous ordered treatments of Lotrimin cream, Nystatin powder and stomahesive powder for the buttocks/groin area continued.

The next assessment of the resident's buttocks and ischium pressure sores was ten days later on 8/18/17. The pressures sores were assessed on 8/18/17 as follows: Right buttocks stage III pressure sore measuring .9 cm x 2.6 cm x 0.2 cm with no drainage; Right buttocks stage III pressure sore measuring 1.6 cm x 1.3 cm x 0.2 cm with scant drainage; Left ischium stage II pressure sore measuring 1.0 cm x 1.0 cm x 0.1 cm with no drainage; Crack between buttocks with excoriation measuring 2.0 cm x 0.4 cm x 0.1 cm.

As of 8/29/17 at 4:00 p.m. the clinical record documented no further assessments of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 314	Continued From page 43	F 314		

#22's pressure sores. The last assessment was eleven days prior on 8/18/17.

On 8/30/17 at 1:30 p.m. accompanied by the registered nurse unit manager (RN #3), Resident #5's buttocks/ischium wounds were observed. The resident's buttocks area was red with excoriation present on both buttock cheeks and the scrotum. There were small pinpoint sized open areas scattered across both buttock cheeks. This included a small open area over the left ischium and two small open areas on the right buttocks. There was a small linear open area between the cheeks in the coccyx area.

On 8/30/17 at 1:45 p.m. the registered nurse unit manager (RN #3) was interviewed about any notification to Resident #5's physician about pressure sore development and changes in the condition of the wounds assessed on 8/8/17. RN #3 stated he started working at the facility in August 2017 and he saw the "2 open areas" assessed on 7/25/17 with only one pressure sore listed with measurements so he wanted to re-assess the wounds. RN #3 stated he and licensed practical nurse (LPN) #7 re-assessed Resident #5's buttocks/coccyx areas on 8/8/17 and identified the stage III pressure sores on the buttocks and the stage II pressure sore on the ischium. RN #3 stated LPN #7 was supposed to notify the physician. RN #3 stated he would look for any documentation concerning notification. RN #3 stated all of the resident's buttock/ischium wounds were improved today (8/30/17) as compared to his previous assessment on 8/8/17.

On 8/30/17 at 4:50 p.m. RN #3 stated he did not find any notification to the physician about Resident #5's pressure sores or change in wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 314	Continued From page 44	F 314		

status. RN #3 stated nurses were supposed to document any notifications in the nursing notes. RN #3 stated pressure ulcers and wounds were supposed to be assessed each week and include measurements. RN #3 stated pressure sore assessments were supposed to be documented on the pressure ulcer tracking form.

Resident #5's care plan (revised 8/29/17) listed the resident had excoriation to his groin, buttocks and sacrum in addition to new pressure wounds on his right buttock and left ischium. Interventions listed to promote healing and prevent further skin breakdown included, "Conduct weekly head to toe skin assessments and report abnormal findings to physician and chart in nurses notes...Observed for signs of infection...and report to physician..."

The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure injury as, "localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear." The NPUAP defines a stage II pressure injury as, "Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible..." The NPUAP defines a stage III pressure injury as, "Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible..." (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 314	Continued From page 45 These findings were reviewed with the administrator and director of nursing during a meeting on 8/30/17 at 2:00 p.m. (1) NPUAP Pressure Injury Stages. 2016. National Pressure Ulcer Advisory Panel. 9/1/17. www.npuap.org/	F 314		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 334		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 334	Continued From page 46 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review	F 334	Resident # 12□s responsible party	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 334	Continued From page 47 and facility document review, the facility staff failed to ensure the influenza and or the pneumococcal was offered and administered to two of 25 residents, Resident #7 and 12 and failed to obtain consent prior to the administration of the influenza vaccine for two of 25 residents, Resident #2 and 10. 1. Resident #12 was not offered the pneumococcal vaccine. 2. Resident #7 was not offered the influenza vaccine. 3. Resident #2 did not have a consent prior to the administration of the influenza vaccine. 4. Resident #10 did not have a consent prior to the administration of the influenza vaccine. The findings include: 1. Resident #12 was not offered the pneumococcal vaccine Resident #12 was originally admitted to the facility on 4/6/07 and readmitted on 2/15/13 with, but not limited to, the following diagnoses: coronary artery disease, peripheral vascular disease with right above the knee amputation, hypertension and dementia. The most recent Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 6/27/17 was a quarterly assessment. The resident was assessed as being a three (3) for cognitive skills, severely impaired in decision-making skills. On 8/30/17 at approximately 11:00 a.m., Resident	F 334	consented for the pneumococcal vaccine and the vaccine has been administered. Resident # 7 and # 10 responsible parties have consented to a flu vaccine and will be given during our annual flu vaccine program. Resident # 2□s missing consent form was located. All residents have the potential to be affected by this practice. All residents will be offered the flu and pneumonia vaccine if indicated. Consent forms will be offered and signed prior to administration of the vaccines. The ADON/designee will educate all licensed nursing staff RNs/LPNs will be on the facilities current immunization policy to include the need to offer the pneumonia and flu vaccine and obtain permission prior to administration. The ADON will complete a weekly audit of 10% of current residents for 3 months to ensure permissions for vaccines are obtained and the vaccine is offered. Any variances will be corrected and continued education will be provided. The ADON will report results of the audits to the facilities QA committee for 3 months. Continued compliance will be monitored through the facilities 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
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 334	Continued From page 48	F 334		

#12's clinical record was reviewed. A copy of the facility's "Immunization Record" was observed in the clinical record. Under the section for "Pneumococcal Vaccination" it was blank. The MDS with an ARD of 6/27/7 was reviewed, under "Section O Special Treatments, Procedures, and Programs it was documented, B. If pneumococcal vaccine not received, state reason: Enter code three (3) was documented, Not offered."

On 8/30/17 at approximately 3:02 p.m., the administrative staff were made aware of the above findings. The regional nurse consultant stated, "Let me see what I can find for you."

On 8/31/17 at approximately 12:01 p.m., during the meeting with the administrative staff, the regional nurse consultant stated, "I cannot find anything further for the immunizations, it was not done."

2. Resident #7 was not offered the annual flu vaccine.

Findings were:

Resident #7 was admitted to the facility on 10/13/2011. Her diagnoses included, but were not limited to: Dysphagia, cerebral vascular accident (stroke) hypertension and right sided weakness.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/25/2017. Resident #7 was assessed as having a cognitive summary score of "08"; indicating moderate impairment with her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 334	Continued From page 49	F 334		

cognitive status.

Review of the clinical record on 08/30/2017 included review of an annual MDS with an ARD of 01/31/2017. Under "Section O Special Treatments, Procedures, and Programs", Item "O 0250. Influenza Vaccine", contained the following: "Did the resident receive the influenza vaccine in this facility for this year's influenza season?" The item was answered: "No." The next item: "If influenza vaccine not received, state reason: "Not offered". The quarterly MDS, with an ARD of 07/25/2017 was reviewed for any updated influenza information. The items under "Section O" were coded the same.

The clinical record was reviewed for additional documentation regarding the flu vaccine administration for the 2016 flu season. There were no notes in the clinical record, physician orders, consents, or entries on the MAR (medication administration record) indicating that the flu vaccine had been offered or given.

On 08/30/2017, at approximately 3:00 p.m., the DON (director of nursing) was asked if there was any information regarding the vaccine. She and RN (registered nurse) came to the conference room to speak with this surveyor. Admin #3 stated, "Here is the documentation we can find." She presented a typed page of resident names with a header "Unit 2-Flu Shots that may be given as of 10/25/2016". Included on the page were directions for administration. Resident #7 was listed on the page. Resident #7 was also listed on an additional page, indicating that the flu shot would be given on 12/8/2016. "We don't know if she ever received the vaccine or not...we tracked the residents who got the flu and she wasn't one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(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 334	Continued From page 50	F 334		

of them, but we treated everyone prophylactically with Tamiflu when we had an outbreak..."

The facility policy regarding flu vaccines was requested. Per the policy, "FLU VACCINE", the following information was obtained: "The facility will provide education and offer the flu vaccine to guests upon admission and annually thereafter to protect guests and to prevent an outbreak of influenza....Procedure...Obtain the consent or declination of the guest/family member/legal representative on page 2 of the Immunization Record...Obtain a physician's order to administer the flu vaccine if the guest wishes to receive the vaccine...It is recommended to administer the vaccine starting on October 1st and no later than November 30th for in-house guests unless the physician requests a delay because of a later flu season...Document the administration of the flu vaccine on the Medication Administration Record..."

The above information was discussed during an end of day meeting on 08/30/2017 with the facility administrator, DON and corporate consultants.

No further information was obtained prior to the exit conference on 08/31/2017.

3. The facility staff failed to obtain consent prior to the administration of influenza vaccine for Resident # 2.

Resident # 2 was admitted to the facility 4/11/17 with diagnoses to include, but not limited to: dementia, diabetes, high blood pressure, and emphysema.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

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THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 334	Continued From page 51	F 334		

The most recent MDS (minimum data set) was a quarterly review dated 6/20/17. Resident # 2 was coded as having long term and short term memory problems, and moderate impairment in daily decision making skills.

The clinical record was reviewed 8/29/17 at 1:00 p.m. The clinical record included an immunization record, which was a two page document. The document had the resident's name and physician name handwritten on both pages of the document, but no other documentation was noted on either page. Page two of the document was titled "Acknowledgement of Receipt of Vaccine Information Sheet (VIS)." There was a place for the resident's name and date of birth, as well as a space for staff to document the VIS publication date, whether the influenza vaccination was accepted or declined, if the vaccine was to be given yearly, and a space for the resident or the resident's representative, as well as staff representative administering the vaccine to sign. The entire section for page two was blank.

During a meeting 8/30/17 beginning at 1:55 p.m. the regional nurse consultant was asked about the immunization record in Resident # 2's clinical record, and if the information was located anywhere else. The regional nurse consultant stated she would see what she could find, and if there was any documentation of consent from the resident's family for the administration of the influenza vaccine.

On 8/31/17 during a meeting with facility staff beginning at 12:00 p.m. the regional nurse consultant informed this surveyor that no documentation could be located for the consent

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	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 334	Continued From page 52	F 334		

of the resident's influenza vaccine.

The facility policy " FLU VACCINE " directs: "3. Obtain the consent or declination of the guest/family member/legal representative on page 2 of the Immunization Record." 12. File the immunization record in the guest's active medical record."

No further information was provided prior to the exit conference.

4. The facility staff failed to obtain consent prior to the administration of influenza vaccine for Resident # 10.

Resident # 10 was admitted to the facility 2/13/17 with diagnoses to include, but not limited to: muscle weakness, dementia, history of hip fracture, and low thyroid.

The most recent MDS (minimum data set) was a quarterly review dated 8/16/17. Resident # 10 was coded as having short term and long term memory problems, and severe impairment in daily decision making skills.

Resident # 10's clinical record was reviewed 8/29/17 at 1:30 p.m. The clinical record included an immunization record, which was a two page document. The document had the resident's name and physician name handwritten on both pages of the document, but no other documentation was noted on either page. Page two of the document was titled "Acknowledgement of Receipt of Vaccine Information Sheet (VIS)." There was a place for the resident's name and date of birth, as well as a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 334	Continued From page 53 space for staff to document the VIS publication date, whether the influenza vaccination was accepted or declined, if the vaccine was to be given yearly, and a space for the resident or the resident's representative, as well as staff representative administering the vaccine to sign. The entire section for page two was blank. During a meeting 8/30/17 beginning at 1:55 p.m. the regional nurse consultant was asked about the immunization record in Resident # 10's clinical record, and if the information was located anywhere else. The regional nurse consultant stated she would see what she could find, and if there was any documentation of consent from the resident's family for the administration of the influenza vaccine. On 8/31/17 during a meeting with facility staff beginning at 12:00 p.m. the regional nurse consultant informed this surveyor that no documentation could be located for the consent of the resident's influenza vaccine. The facility policy " FLU VACCINE " directs: "3. Obtain the consent or declination of the guest/family member/legal representative on page 2 of the Immunization Record." 12. File the immunization record in the guest's active medical record." No further information was provided prior to the exit conference.	F 334		
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets	F 367		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 367	Continued From page 54 (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide a therapeutic diet as ordered by the physician for one of 25 residents in the survey sample. Resident #5 was served a puree diet when the physician's order required a mechanical soft diet. A diet communication slip sent to the kitchen did not match the physician ordered diet for Resident #5. The findings include: Resident #5 was admitted to the facility on 7/22/13 with diagnoses that included high blood pressure, diabetes, benign prostatic hypertrophy with obstructive uropathy and depression. The minimum data set (MDS) dated 7/25/17 assessed Resident #5 with short and long-term memory loss and moderately impaired cognitive skills. This assessment indicated the resident had experienced a significant weight loss and was not on a prescribed weight loss program. Resident #5's clinical record documented a physician's order dated 8/8/17 for a mechanical soft diet with thin liquids with chicken noodle soup allowed. On 8/30/17 at 8:10 a.m. Resident #5 was	F 367	Resident # 5□s dietary communication slip was corrected to match the physician□s order on 8/30/17. All residents have the potential to be affected by this practice. The Dietary Manager will complete a 100% audit of current residents□ diet communication slips to ensure they match current physician orders for therapeutic diets. Any variances will be corrected and continued education will be provided. The DON will educate all licensed nursing staff and dietary staff on assuring all dietary communication slips and physician orders are accurate and reflect current therapeutic diets. The Dietary Manager will audit 10% of all resident□s therapeutic diet orders weekly for 3 months to ensure accuracy of diets. Any variances will be corrected and continued education will be provided. The Dietary Manager will report results of the audits to the facilities QA committee for 3 months.	

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	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 367	Continued From page 55 observed in the dining area with breakfast. The resident was served pureed breakfast food items with juice and water. The resident's diet slip documented a pureed carbohydrate controlled diet. On 8/30/17 at 9:00 a.m. the registered nurse unit manager (RN #3) was interviewed about Resident #5's ordered therapeutic diet. RN #3 stated the last order in the system was dated 8/8/17 for mechanical soft food items, thin liquids with chicken noodle soup allowed. RN #3 stated he did not know why puree food items were served for breakfast. On 8/30/17 at 9:35 a.m. the dietary manager was interviewed about Resident #5's diet order. The dietary manager stated she had a dietary communication slip indicating a puree diet with thin liquids. This slip presented by the dietary manager was signed by a nurse but had no date on the slip. There was no current physician's order for a pureed diet. On 8/30/17 at 9:37 a.m. the licensed practical nurse (LPN #4) caring for Resident #5 was interviewed about the diet orders. LPN #4 stated the pureed order was old and the latest order was for the mechanical soft diet with thin liquids. On 8/30/17 at 11:30 a.m. the speech therapist that had treated Resident #5 was interviewed about the recommended therapeutic diet. The speech therapist stated she did not know anything about the undated dietary slip indicating a pureed diet. The speech therapist stated the last recommendation was on 8/8/17 for a mechanical soft diet with thin liquids and the allowance for chicken noodle soup. The speech	F 367	Continued compliance will be monitored through the facilities 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
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 367	Continued From page 56 therapist stated she did not enter orders but made recommendations. The speech therapist stated the recommendations were communicated to the physician by nurses. The speech therapist stated after a physician order was received nurses sent the communication slip to the kitchen. The speech therapist stated she did not write the dietary slip for the pureed diet and was not sure when or who sent it to the kitchen. These findings were reviewed with the administrator and director of nursing during a meeting on 8/30/17 at 2:00 p.m.	F 367		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		10/6/17

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	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 431	Continued From page 57 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to store unopened insulin pens per manufacturer's recommendations in two of two medications carts on one of three units, Unit 3. The findings include: The medication carts on Unit 3 were observed	F 431	Pharmacy was called and provided information that insulin could be refrigerated and stored due to less than 24 hours of exposure. The insulin pens were stored per manufacture recommendation upon notification of practice. All residents receiving insulin have the	

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	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 431	Continued From page 58 with unopened insulin pens. On 8/30/17 at approximately 11:10 a.m., during the medication cart observation on Unit three the following was observed. The first medication cart observed with a licensed practical nurse, who will be identified as LPN #1 was observed with three unopened insulins pens in the medication cart. The label on the insulin bags were documented, "Refrigerate." LPN #1 was interviewed regarding the insulin pens being on the medication cart and not refrigerated as documented. LPN #1 stated, "They are supposed to be refrigerated until opened. They were delivered last night and I guess they forgot to put them in the refrigerator." On 8/30/17 at approximately 11:17 a.m. the second medication cart on Unit three was observed with a licensed practical nurse, who will be identified as LPN #2, with two unopened insulin pens in the medication cart. The label on the insulin bags were documented, "Refrigerate." LPN #2 was interviewed regarding the insulin pens being on the medication cart and not refrigerated as documented. LPN #2 stated, "I will put them in the refrigerator now, they are supposed to be in the refrigerator." On 8/30/17 at approximately 11:20 a.m., the unit manager, who was a registered nurse and will be identified as RN# 1, was interviewed regarding the unopened insulins pens on the medication cart, RN # stated, "They don't ever put those in the refrigerator, they are aware it needs to be in the refrigerator, it says refrigerate on the bag, but I assume we don't know." On 8/30/17 at approximately 4:30 p.m., the regional nurse consultant and RN #1 entered the	F 431	potential to be affected by this practice. The DON completed an audit of all medication carts to ensure all insulin is stored per manufacture guidelines. The DON/designee will educate all licensed nursing staff on manufacture recommendations for storage of insulin pens. The nurse administration team will complete weekly medication cart audits for 3 months to ensure proper storage of insulin. Any variances will be corrected and continued education will be provided. The DON will report results of the audits to the facilities QA committee for 3 months. Continued compliance will be monitored through the facilities Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns.	

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	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 431	Continued From page 59 conference room and stated, "We called the pharmacy and they said the insulin was good for twenty-four hours." A copy of the facility's policy was requested, the regional nurse stated, "We do not have a policy here for the insulin pen but I will call the pharmacy and see if they have one." On 8/31/17 at approximately 1:15 p.m. a copy of the "Lily Insulin Products Storage and Stability" policy was reviewed to include the following: "... Not-in-Use (Unopened) Vials, Kwik-pen and Cartridges. Not-in-use (unopened) insulin products, including vials, Kwik-pens and cartridges must be stored in a refrigerator [36 degrees Fahrenheit to 46 degrees Fahrenheit (2 degrees Celsius to 8 degrees Celsius)] to maintain the physical and chemical stability of the product throughout its shelf-life. Storage of unopened products at room temperature is not recommended..."	F 431		
F 514 SS=D	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	F 514		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 514	Continued From page 60 (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (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 staff interview and clinical record review, facility staff failed to ensure a complete and accurate clinical record for two of 25 residents in the survey sample, Residents #4 and #7. 1. Facility staff failed to complete entries on Resident #4's MAR (medication administration sheet) and TAR (treatment administration sheet) during the month of August 2017. 2. The Kardex located inside Resident #7's closet door was a Kardex for a different resident in the facility. Findings included:	F 514	Resident # 4□s physician was notified of the omissions and the responsible party was notified. No harm came related to this practice. The Care Card found in Resident # 7□s closet was placed in the appropriate resident□s room. All residents have the potential to be affected by this practice. The nurse administration team will review all new admissions and current resident missed administrations on medication and treatment records 5x/week for 4 weeks to ensure the medication administration records and treatment administration records are free of omissions. The nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 514	Continued From page 61 1. Resident #4 was originally admitted to the facility on 08/17/2005 and readmitted on 04/09/2017 with diagnoses including, but not limited to: Left Hip Fracture with ORIF (open reduction internal fixation), Diabetes, Hypertension, Alzheimer's Disease, Depression, Anxiety and Psychosis. The most recent MDS was a quarterly assessment with an ARD of 07/12/17. Resident #4 was assessed as severely impaired in her cognitive skills with a total cognitive score of three out of 15. Resident #4's clinical record was reviewed on 08/29/17 at 1:30 p.m. During this review the MAR's and TAR's for the current month of August 2017 were found incomplete. The following medications and treatments were noted with blank boxes on the administration sheets: Humalog 100 units/ml - 6:30 a.m. - 8/2, 8/5; 11:30 a.m. - 8/5 Blood Sugar Results - 6:30 a.m. - 8/1, 8/2, 8/5, 8/6; 11:30 a.m. - 8/2, 8/3, 8/4, 8/5, 8/6; 5:30 p.m. - 8/1, 8/2, 8/4, 8/5 Lantus 100 units/ml - 9:00 p.m. - 8/19, 8/20, 8/23 Novolog 100 units/ml - 6:30 a.m. - 8/10, 8/12, 8/16, 8/18, 8/25; 5:30 p.m. - 8/20 Blood Sugar Results - 6:30 a.m. - 8/7, 8/10, 8/12, 8/13, 8/14, 8/15, 8/16, 8/18, 8/20, 8/24, 8/25; 11:30 a.m. - 8/7, 8/9, 8/10, 8/11, 8/12, 8/13, 8/15, 8/19, 8/21, 8/23, 8/26, 8/27, 8/28; 5:30 p.m. - 8/6, 8/11, 8/15, 8/18, 8/20, 8/22, 8/25 Omeprazole 25mg - 6:30 a.m. - 8/2, 8/10, 8/12,	F 514	administration team will complete an audit of all resident rooms 3x/week for 4 weeks to ensure Care Cards are located in the proper resident room. Any variances will corrected and continued education provided. The ADON/designee will educate all licensed nurse staff on the 5 rights of medication administration to include documentation of medications and treatment administrations along with ensuring that care cards are placed in the correct resident rooms. Continued compliance will be monitored through the facilities 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
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 62 8/16, 8/18, 8/25 Supplement - 2:00 p.m. - 8/5, 8/17, 8/18, 8/20 Supplement - 8:00 p.m. - 8/17, 8/19, 8/20 Adaptive Equipment every night, guest to wear palmguards nightly while sleeping - 8/4, 8/9, 8/15, 8/17, 8/23, 8/24 Safety Alarm - Bed, Check Every Shift - Day - 8/5, 8/17, 8/18, 8/25; Evening - 8/11, 8/17, 8/19 Night - 8/4, 8/9, 8/15, 8/17, 8/23, 8/24 Safety Alarm - Chair, Check Every Shift - Day - 8/5, 8/17, 8/18, 8/25 Evening - 8/11, 8/17, 8/19 Night - 8/4, 8/9, 8/15, 8/17, 8/23, 8/24 Treatment Twice Daily - t.e.d. hose (knee high) on in am, off in pm - Day - 8/5, 8/17, 8/18, 8/25; Evening - 8/11, 8/17, 8/19 Wander Bracelet - Check Every Shift - Day - 8/5, 8/17, 8/18, 8/25 Evening - 8/11, 8/17, 8/19 Night - 8/4, 8/9, 8/15, 8/17, 8/23, 8/24 On 08/30/17 at 11:00 a.m., RN #3 (registered nurse), Nurse Manager on Unit #2, was interviewed regarding blanks on the MAR's and TAR's and if blood sugar's are documented anywhere other than on the MAR. RN #3 stated, "I would think blood sugars are charted on the EMAR. I am not aware of anywhere else. There isn't a book or anything." The Administrator and DON (director of nursing)	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 08/31/2017

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F 514	Continued From page 63	F 514		

were informed of the above during a meeting with the survey team on 08/30/17 at approximately 2:00 p.m. No further information was received prior to the exit conference on 08/31/17.

2. The KARDEX located in Resident #7's closet, which is what the CNAs (certified nursing assistants) use to render care, was not hers and belonged to a resident in the adjacent room.

Resident #7 was admitted to the facility on 10/13/2011. Her diagnoses included, but were not limited to: Dysphagia, cerebral vascular accident (stroke) hypertension and right sided weakness.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/25/2017. Resident #7 was assessed as having a cognitive summary score of "08"; indicating moderate impairment with her cognitive status.

On 08/29/2017 at approximately 2:20 p.m., Resident #7 was observed lying on her bed. She was covered up and her eyes were closed. Her legs/feet did not appear to be elevated off of the bed.

This surveyor went to the nurse's station to see who the CNA (certified nursing assistant) for Resident #7 was. A staff person at the desk stated that the CNA assigned to Resident #7 was on break, but she was being cared for by CNA # 2. This surveyor found CNA # 2 and asked her if

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F 514	Continued From page 64	F 514		

Resident #7's heels were floated (off of the bed). She went to the room and uncovered the resident. Resident #7's heels were not floated and were resting on the mattress. CNA # 2 stated, "I didn't get her in bed...I didn't know her heels were suppose to be up...I don't see one of those blue things [heelz up pad]...I'll get something."

While CNA # 2 was looking for something to elevate Resident #7's heels with, CNA # 3 returned from break. She was asked about Resident #7's heels. She stated, "Are they suppose to be floated?" CNA # 3 was asked if she had know that. She stated, "No." She was asked if Resident #7 had a Kardex care plan for the CNAs to follow. She stated, "Yes, it's in her closet." CNA # 3 and this surveyor looked at the Kardex. "Float heels was checked as an intervention for the CNAs to follow." CNA # 3 stated, "I see that, I'll take care of it."

As this surveyor was taking the Kardex to the nurse's station for a copy, it was noted that the Kardex did not have Resident #7's name on it, but the name of a resident in the room next door. The Kardex was returned to Resident #7's room and shown to CNA # 3. She sated, "Oh I see that...we don't put them in here, I didn't notice that."

The unit manager was approached about the Kardex. He stated, "I update them and put them in the room...yes, that's a problem if the wrong one was in there."

The above information was discussed during an end of day meeting on 08/30/2017 with the facility administrator, DON and corporate consultants.

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F 514	Continued From page 65 No further information was obtained prior to the exit conference on 08/31/2017.	F 514		