STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/12/2019 through 03/14/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/12/19 through 3/14/19. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 120 certified bed facility was 116 at the time of the survey. The survey sample consisted of 40 current resident reviews and 13 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		4/26/19

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

Electronically Signed | 04/05/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to serve food in a manner to promote resident dignity for one of 53 residents in the survey sample, Resident # 264. The facility staff failed to serve food in a manner to promote dignity in the facility's main dining room. Resident # 264 waited twenty-two minutes to receive her lunch meal, after her tablemate was served and eating the lunch meal.	F 550	1. Resident #264 no longer resides in facility. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All nursing staff will be educated to serve food in a manner to promote resident dignity. 4. All meals will be observed in all dining rooms 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure that meals are being served to promote resident dignity. Monitoring will include tracking and	

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 550	Continued From page 2 The findings include Resident # 264 was admitted to the facility on 03/11/2019 with diagnoses that included but were not limited to: fractured right hip and swallowing difficulty. Resident # 264's MDS (minimum data set) was not due to be completed at the time of the survey. The facility's nursing admission assessment dated 03/11/2019 documented Resident # 264 was orientated to person, non-weight bearing and totally dependent of staff for transfers and toileting. The baseline care plan for Resident # 264 dated 03/11/2019 documented, "ADL (activities of daily living) Functional / Rehab (rehabilitation) Potential" documented, "Bathing/Hygiene w/assist (with assistance) of 1 (one) (staff member); Dressing/grooming w/assist of 1; Eating w/assist of 1; Toileting w/assist of 1; Ambulation/transferring w/assist of 2 (two) (staff members)." Under "Nutritional Status / Diet" it documented, "Diet as ordered: Full Liquid." On 03/12/19 at 12:10 p.m., an observation was conducted of the facility's main dining room. Observation of Resident # 264 revealed she was sitting at a table in the dining room across the table from another resident and their family member. At approximately 12:15 p.m., the resident sitting opposite of Resident # 264 received her meal and began eating with assistance from their family member. Observation of Resident # 264 revealed she remained at the table while the other resident was eating and did not receive her meal until 12:37, twenty-two minutes later.	F 550	trending of issues found during the dining room observations. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine dining room observations completed by the DON or designee and will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 550	Continued From page 3 On 03/13/19 at 11:18 a.m., an interview was conducted with CNA (certified nursing assistant) # 6. When asked about Resident # 264 not being served her lunch at the same time the other resident at her table received her lunch, CNA # 6 stated, "I not real familiar with (Resident # 264). Yesterday in the dining room was the first time I saw her." When asked to describe the procedure for serving residents who are at the same table for a meal, CNA # 6 stated, "We serve everybody at the same table at the same time." When asked why that procedure is followed, CNA # 6 stated, "Its's not good to have one person eating and everyone else watching." When asked if this was dignified for Resident # 264 to wait for her meal while the other resident at the table was eating, CNA # 6 stated, "No, it is dignified to have everyone eating together." When asked how it may make someone feel, having to wait for their meal, while someone else at the table is already eating, CNA # 6 stated, "It could make them feel uncomfortable, like we forgot them and that they're not going to eat." On 03/13/19 at 3:11 p.m., an interview was conducted with OSM (other staff member) # 15, the acting dietary manager. When informed of the observation on 03/12/19 during lunch of Resident # 264 not being served her meal at the same time as the other resident at the same table, and waiting for twenty-two minutes for her meal, OSM # 15 stated, "They should not have to wait. The resident was supposed to receive her meal in her room and she was in the dining room. It still should have not taken that long. OSM # 15 was asked to describe the process for serving residents seated at the same table. OSM # 15 stated, "When serving the tables, when the first	F 550		

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 550	Continued From page 4 resident is served and they (staff/aides) go to get the next tray for the resident at the table and saw it wasn't there, the aide should have notified the kitchen right away, we could have looked up the diet order and got the tray in a shorter period of time." The facility's policy "Fine Dining/Restaurant-Style Dining Overview" documented, "12. All guest seated at the same table shall be served meals at the same time." On 03/13/19 at approximately 5:20 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing and ASM # 3, regional director of operations were made aware of the findings. No further information was provided prior to exit.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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- §483.10(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	F 584		4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 584	Continued From page 5 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, family interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to maintain and clean, comfortable, homelike environment for two of 53 residents in the survey sample, Residents #20 and #92 and for 74 of 78 resident rooms. 1. The facility staff failed to clean and store a bedpan in a sanitary manner and failed to repair a hole in the cove base at the bottom of the wall in Resident #20's bathroom.	F 584	1. The bedpan in the room of resident #20 has been removed and the hole in the cove base at the bottom of the wall has been repaired. Resident #92's bathroom is being maintained in a sanitary manner and the hole in the cove base at the bottom of the wall has been repaired. The heating/air conditioning units in all rooms in the facility have been cleaned and are functioning properly. All light covers in resident rooms have been dusted and cleared of residue. 2. All residents have the potential to be affected by these alleged deficient	

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 584	Continued From page 6 2. The facility staff failed to maintain Resident #92's bathroom in a sanitary manner and failed to repair a hole in the cove base at the bottom of the wall. 3. The facility staff failed to maintain the heating/air conditioning units in rooms #103, #104, #105, #108, #109, #200, #202, #203, #204, #206, #209, #301, #302, #307, #401, #402, #501, #601, #606 and #705 in a clean and comfortable manner. 4. The facility staff failed to ensure light covers in multiple resident rooms were maintained in a clean and comfortable homelike manner. Gray residue and/or dust dirt was observed on top of the light covers in multiple resident rooms. The findings include: 1. The facility staff failed to clean and store a bedpan in a sanitary manner and failed to repair a hole in the cove base at the bottom of the wall in Resident #20's bathroom. Resident #20 was admitted to the facility on 5/16/18 with diagnoses that included but were not limited to, heart failure, sleep apnea (a condition in which the patient has transient periods of apnea during sleep) (1), obesity, diabetes and depression. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 1/10/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring	F 584	practices. 3. All housekeeping staff will be retrained on how to maintain a sanitary resident room and bathroom, including heating/air conditioning units and light covers. All nursing staff will be educated on proper storage of bedpans in resident bathrooms. Maintenance director will be trained to identify damaged cove base molding and make necessary repairs. 4. 20 resident rooms and bathrooms will be audited for: appropriate storage of bedpans; cove base molding damage; clean/dust-free heating/air conditioning units and light covers; and clean and sanitary bathrooms. 20 rooms will be audited 5 times a week for 4 weeks, 3 times a week for 2 weeks and then 1 time weekly for 4 weeks. Monitoring will include tracking and trending of issues found during the room observations. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine room observations completed by the DON or designee and will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 7	F 584		

extensive assistance of two or more staff members for her toileting needs.

Observation was made of Resident #20's bathroom on 3/12/19 at 4:26 p.m. A blue bedpan was observed on the floor, not in a bag, with three dark brown pieces of what appeared to be stool in it. There was a hole approximately two inches by two inches in the cove base at the bottom of the wall facing the door. When asked how long the bedpan had been on the floor, Resident #20 and her roommate both stated, "A long time." The roommate stated she uses the bathroom.

Observation was made of Resident #20's bathroom on 3/13/19 at 9:26 a.m. A blue bedpan was observed on the floor, not in a bag, with three dark brown pieces of what appeared to be stool in it. There was a hole approximately two inches by two inches in the cove base at the bottom of the wall facing the door.

Observation was made of Resident #20's bathroom again on 3/14/19 at 8:15 a.m. The bedpan remained in the same place. The hole remained on the bottom of the wall.

Observation was made of Resident #20's bathroom on 3/14/19 at 8:32 a.m. with OSM (other staff member) # 1, the director of housekeeping. The bedpan had been removed from the bathroom. Resident #20 stated the CNA (certified nursing assistant) # 5 had just removed it from the bathroom. OSM #1 was asked if his staff should do anything with the dirty bedpan on the floor, OSM #1 stated his staff does not do anything with the bedpan but it's a team around here and they should have said something to the nursing staff about it. The hole in the wall was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

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F 584	Continued From page 8	F 584		

observed. OSM #1 stated it shouldn't be there and he was going to tell the maintenance director.

An interview was conducted with CNA #5 on 3/14/19 at 8:40 a.m. When asked what she removed from Resident #20's bathroom, CNA #5 stated she removed a bedpan and a female urinal. When asked if there was anything in the bedpan, CNA #5 stated, "Yes, there was a couple drops of feces in it." CNA #5 was asked to explain the process for cleaning and storing of bedpans, CNA #5 stated, "I would first rinse the bedpan with the sprayer that's in the bathroom. Then after it's clean, I put it in a clean trash bag and tie it to the handrail in the bathroom." When asked if the bedpan she removed from the bathroom was stored properly, CNA #5 stated, "No, Ma'am. If you see it you should remove it."

An interview was conducted with RN (registered nurse) #5 on 3/14/19 at 8:49 a.m. When asked how are bedpans to be stored when not in use, RN #5 stated they should be cleaned and put in a plastic bag. When asked if a bedpan should be stored unbagged with feces in the bedpan on the floor of a resident's bathroom, RN #5 stated, 'No, anyone making rounds should do something about it if they see it."

The facility policy, "Bedpans" documented in part, "17. Dispose of urine and/or stool in the commode. 18. Remove and clean equipment and place soiled items in appropriate receptacles. Note: The bedpan should be clean and dry before storing."

Administrative staff member (ASM) #1, the administrator and ASM # 3, the regional director of operations, we made aware of the above

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9	F 584		

concern on 3/14/19 at 4:33 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 534.

2. The facility staff failed to maintain Resident #92's bathroom in a sanitary manner and failed to repair a hole in the cove base at the bottom of the wall.

Resident #92 was admitted to the facility on 1/24/19 with diagnoses that included but were not limited to: brain cancer, muscle weakness, diabetes, depression, and high blood pressure.

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 2/20/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable or making daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for his toileting needs.

An interview was conducted with Resident #92 and his wife on 3/12/19 at 11:21 a.m. When asked if the facility keeps his room clean, Resident #92's wife stated the room is clean but the bathroom is not. Observation was made of the bathroom in Resident #92's room. A brown substance that appeared to be feces was observed on the sprayer hose next to the toilet. There was a brown debris where the wall and floor meet behind the toilet. There was a brown substance around the base of the toilet. A hole

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

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F 584	Continued From page 10	F 584		

was observed, approximately two inches by two inches in the cove base at the base of the wall opposite the door.

The bathroom was again observed on 3/12/19 at 3:43 p.m., and 3/13/19 at 8:49 a.m. and again on 3/14/19 at 8:15 a.m. the observations above remained unchanged.

An interview was conducted with other staff member (OSM) #1, the housekeeping director, and OSM #10, the director of maintenance, on 3/14/19 at 8:22 a.m. When shown Resident #92's bathroom, and asked if the hole should be in the wall, OSM #10 stated, "No, it should be repaired." The brown substance around the base of the toilet was shown to both staff. When asked what the brown substance was, OSM #10 stated, "The toilet needs to resealed." The brown substance, that appeared to be feces, was shown to OSM #1, OSM #1 stated, "That shouldn't be there, that needs to be cleaned. When asked about the black debris and brown around the base of the toilet, OSM #1 stated, "This all needs to be cleaned."

An interview was conducted with administrative staff member (ASM) #3, the regional director of operations, on 3/14/19 at 11:07 a.m. When asked how often the bathrooms in resident's rooms are cleaned, ASM #3 stated, "If the room is occupied, then it should be cleaned daily."

An interview was conducted with CNA (certified nursing assistant) #4 on 3/14/19 at 11:10 a.m. When asked how and to who, staff communicate broken items in need of repair in a resident's room, CNA #4 state, I walk around to the maintenance department or I tell the secretary to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 584	Continued From page 11 call them." An interview was conducted with OSM #10, the director of maintenance, on 3/14/19 at 1:52 p.m. When asked how he is informed of things that need to be fixed, OSM #10 stated, "The computer system - Tels." When asked who has access to it, OSM #10 stated all of the staff has access to it. An interview was conducted with OSM #9, the unit secretary, on 3/14/19 at 2:08 p.m. When asked what Tels was, OSM #9 stated she would find out and get back with me. At 3:02 p.m., OSM #9 returned to this surveyor and stated it is a work order system for maintenance and housekeeping. When asked if she uses it, OSM #9 stated, "No, It's quicker for me to just call them." An interview was conducted with ASM #1, the administrator, on 3/14/19 at 2:27 p.m. When asked how the staff tell maintenance about something that is broken, ASM #1 stated, "We have an electronic work order system that everyone has access to. Every computer has an icon for it." The facility policy, "Daily Cleaning of Guest Rooms" documented in part, "Policy: The daily cleaning and disinfecting of guest rooms will maintain the health of our guest and reduce the spread of infection throughout the facility. 4. Proper sequence of cleaning: clean quest room first then proceed to rest room. Use separate cleaning cloth for each area to be cleaned. Clean room in a clock wise direction - high dusting, then clean the following, TV, night stand, window sills, glass items, picture frames, over bed tables, and etc. Move from the cleanest to the dirtiest items	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 12	F 584		

as you clean. "..13. Report any items that need repaired to the maintenance department."

A request was made for the policy on maintenance repairs. On 3/14/19 at 5:32 p.m. OSM #13, the medical records director, informed the survey team the facility had no policy on maintenance repairs.

Administrative staff member (ASM) #1, the administrator and ASM # 3, the regional director of operations, we made aware of the above concern on 3/14/19 at 4:33 p.m.

No further information was obtained prior to exit.
3. The facility staff failed to maintain the heating/air conditioning units in rooms #103, #104, #105, #108, #109, #200, #202, #203, #204, #206, #209, #301, #302, #307, #401, #402, #501, #601, #606 and #705 in a clean and comfortable manner.

On 3/14/19 at 10:00 a.m., observations of the heating/air conditioning units in resident rooms were conducted. Black residue and/or dust/dirt was observed in the heating/air conditioning unit vents in rooms #103, #104, #105, #108, #109, #200, #202, #203, #204, #206, #209, #301, #302, #307, #401, #402, #501, #601, #606 and #705. The black residue and/or dust/dirt could be removed with the swipe of a finger.

Resident #8 was admitted to the facility on 1/23/18. Resident #8's diagnoses included but were not limited to right lower leg fracture, muscle weakness and high blood pressure. Resident #8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/31/18, coded the resident as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 584	Continued From page 13	F 584		

being cognitively intact. Resident #8 resided in one of the above rooms. During the above observation, Resident #8 was made aware this surveyor was going to check her heating/air conditioning unit. Resident #8 stated, "It needs to be cleaned badly."

On 3/14/19 at 10:39 a.m., an interview was conducted with OSM (other staff member) #1 (the housekeeping director). OSM #1 was asked about the facility process for cleaning the vents in the heating/air conditioning units. OSM #1 stated it was difficult to spray and wipe the vents in the units but a deep cleaning is conducted once a month and the housekeeping and maintenance staff removes the units and power washes them outside. OSM #1 stated there had been a little bit of a struggle because the maintenance department was down one employee. At this time, OSM #1 was taken to room #301 and shown the vent in the heating/air conditioning unit. OSM #1 confirmed the unit needed to be cleaned. OSM #1 was made aware of the observations above of the heating/air conditioning units in multiple rooms in need of cleaning.

On 3/14/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional director of operations) and ASM #4 (the regional clinical coordinator) were made aware of the above concern.

The facility policy titled, "Daily Cleaning of Guest Rooms" failed to document specific information regarding the cleaning of heating/air conditioning units.

No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 14 COMPLAINT DEFICIENCY 4. The facility staff failed to ensure light covers in multiple resident rooms were maintained in a clean and comfortable homelike manner. Gray residue and/or dust dirt was observed on top of the light covers in multiple resident rooms. On 03/12/2019 at approximately 11:15 a.m., observations of the light covers in resident rooms were conducted. Gray residue and/or dust dirt was observed on top of the light covers in rooms #100, #101, #102, #103, #104, #105, #106, #109, #200, #202, #203, #204, #205, #206, #207, #208, #209, #210, #211, #300, #301, #302, #303, #304, #305, #306, #307, #308, #400, #402, #403, #404, #405, #406, #407, #408, #409, #500, #501, #502, #503, #504, #505, #506, #507, #508, #509, #510, #600, #601, #602, #603, #604, #605, #606, #607, #608, #609, #610, #701, #702, #703, #704, #705, #706, #707, #708, #709, #710, #711, #712 and #713. The gray residue could be removed with the swipe of a finger. On 03/13/2019 at approximately 8:33 a.m., an interview was conducted with OSM (other staff member) #1 (housekeeping director). OSM #1 was asked about the process staff follows for cleaning and dusting a resident's room. OSM #1 stated that housekeepers high dust resident rooms from ceiling to floor, and then proceed to disinfect and wipe off all furniture and equipment in room after resident has transferred out of the room. OSM #1 stated that this is usually a twelve minute procedure. OSM #1 was asked how he ensures the resident rooms are cleaned. OSM #1 stated, "Myself or another housekeeper would check resident rooms to ensure cleanliness. We also are made aware of housekeeping issues in	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 15 morning meeting from the mock survey rounds." OSM #1 was asked if he made rounds to ensure resident rooms were cleaned. OSM #1 stated that due to a lack of staff, he was assisting in maintenance and had not been able to check rooms. OSM #1 was made of the above observations of the light covers in multiple resident rooms in need of cleaning. On 03/14/2019 at approximately 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional director of operations) and ASM #4 (the regional clinical coordinator) were made aware of the above concern. The facility policy titled, "Daily Cleaning of Guest Rooms" documented, "Proper sequence of cleaning: Clean guest room first then proceed to rest room. Use separate cleaning cloth for each area to be cleaned. Clean room in a clock wise direction - high dusting, then clean the following, TV, night stand, window sills, glass items, picture frames, over bed tables, and etc. Move from the cleanest to the dirtiest items as you clean. " No further information was presented prior to exit.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures	F 607		4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 607	Continued From page 16 to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the facility abuse policy for two of 53 residents in the survey sample, Residents #87 and #89. 1. On 2/14/19 Resident #37 reported an allegation that an employee had raped Resident #87. The facility staff failed to implement the abuse policy for reporting and completing a thorough investigation of the allegation. 2. The facility staff failed to implement the abuse policy for reporting a resident-to-resident altercation when Resident # 89 received a scratch under their eye on 12/07/18. The findings include: 1. On 2/14/19 Resident #37 reported an allegation that an employee had raped Resident #87. The facility staff failed to implement the abuse policy for reporting and completing a thorough investigation of the allegation. Resident #37 was admitted to the facility on 8/4/18. Resident #37's diagnoses included but were not limited to high blood pressure, major depressive disorder and delusional disorders. Resident #37's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/30/19, coded	F 607	1. Resident #37 has not made any additional allegations of abuse. Resident #89 has not had any additional resident to resident altercations. 2. All residents have the potential to be affected by these alleged deficient practices. 3. All staff will be retrained on the abuse policy, reporting guidelines, and completing thorough investigations including what to do if a resident makes an allegation of abuse or a resident to resident altercation occurs. 4. All grievances will be reported to the facility grievance officer or designee when first identified/reported. Facility grievance officer will monitor all investigations for thoroughness and to ensure appropriate and timely reporting has occurred. Facility will interview 30 residents and 30 resident representatives for the next 2 quarters to ensure that no abuse or resident to resident altercations have occurred without facility knowledge. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored as part of the facility's QA process for 6 months. 5. Corrective action will be completed by 4/26/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 17	F 607		

the resident as being cognitively intact. Section G coded Resident #37 as requiring extensive assistance of one staff with bed mobility, toilet use and personal hygiene.

Resident #87 was admitted to the facility on 8/31/18. Resident #87's diagnoses included but were not limited to diabetes, high blood pressure and a fractured right arm. Resident #87's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/28/19, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #87 as requiring extensive assistance of one staff with bed mobility, toilet use and personal hygiene.

On 3/12/19 at 1:53 p.m., an interview was conducted with Resident #37. Resident #37 stated the facility CNAs (certified nursing assistants) were abusive. Resident #37 stated that within the last couple of months, a CNA was in bed with Resident #87 (former roommate). Resident #37 stated the CNA's head was at the level of Resident #87's "titties." Resident #37 stated the CNA was raping Resident #87. When asked if she had reported this information to the facility staff, Resident #37 stated she reported this to the social worker, a nurse and a CNA.

On 3/12/19 at 2:08 p.m. (immediately after the interview with Resident #37), the above allegation was reported to ASM (administrative staff member) #1 (the administrator). ASM #1 stated he was aware of the allegation and would provide additional information.

On 3/13/19 at 4:06 p.m., an interview was conducted with ASM #1. ASM #1 stated Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 18 #37 reported an allegation of rape to the former social worker after Resident #37 was told she was getting a new roommate. ASM #1 stated the social worker interviewed Resident #37 and Resident #37 stated she did not witness the rape but Jesus told her. ASM #1 stated the unit manager interviewed the CNA who allegedly raped Resident #87 and interviewed the resident's son who did not have any concerns. When asked if other staff was interviewed or if Resident #87 was assessed after Resident #37 voiced the allegation, ASM #1 stated Resident #37 stated the alleged rape occurred less than a month after that date but could not remember a date or time. When asked about the facility process for investigating a rape allegation, ASM #1 stated in this case, Resident #37 reported the alleged rape did not occur that day so staff reviewed past skin records and also noticed Resident #87 did not have a change in behavior. ASM #1 was not able to provide evidence that Resident #87 was assessed the day the allegation was reported. When asked to provide evidence that a complete investigation was completed, ASM #1 stated an interview was conducted with Resident #37 and Resident #87's son. ASM #1 stated Resident #87 did have a skin assessment on 2/13/19 (the day prior to the allegation). ASM #1 was asked to provide any further details to evidence a complete and through investigation was conducted. ASM #1 provided a typed document dated 2/14 (no year) that documented, "SW (Social Worker) notified (Resident #37) she is getting a new roommate. (Resident #37) stated, 'Why?' SW stated, 'your roommate's son has requested she be moved to another room' (Resident #37) stated, 'well does he know about (name of CNA)?' SW	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 19	F 607		

stated, 'What?' (Resident #37) stated, 'He got in the bed with her and raped her!' SW informed DON (Director of Nursing) and Administrator of what guest said. Administrator asked SW to investigate this more and get details from guest. SW went back to room and spoke with (Resident #37) about the situation. (Resident #37) stated, 'It was less than a month ago- I can't remember the day or time.' SW asked if guest knew if it was morning or night. (Resident #37) stated, 'Well it would have had to have been day because (name of CNA) works days.' (Resident #37) stated, 'The curtain was pulled so I could see half of (Resident #87). I saw (name of CNA) was lying in bed with her. He was on his left side facing her and I could see the back of his head. His head was not at the same level as her head. His head was at her titty. He was sucking on her titty.' (Resident #37) then stated, 'Then he fucked her.' SW asked guest if she actually saw this happen. (Resident #37) stated, 'Well, no, cause I could only see the half of them, but, the Lord Jesus told me he fucked her.' SW asked if guest said anything during all this. (Resident #37) stated, 'Well (Resident #87) has the dementia ya know.' SW stated she is aware that (Resident #87) has a dx (diagnosis) of dementia, but reiterated the question to (Resident #37), 'Did (Resident #87) say anything during this.' (Resident #37) stated, 'No, she just laid there.' (Resident #37) then stated, 'Well I told the other social worker about this.' SW stated, 'What other social worker?' (Resident #37) stated, 'The black one.' SW stated, '(Resident #37), we had a black social worker over a year ago, but not recently.' (Resident #37) stated, 'Well this was the night before last.' SW asked, 'What was the social worker's name? Did she identify herself as a social worker?' (Resident #37) stated, 'No, one of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 20	F 607		

the aides told me.' SW stated, 'What aide?' (Resident #37) stated, 'Well one of the ones around was (name)...but I'm not sure she told me. One of the aides told me this person was a social worker but I'm not sure who.' SW asked, 'What was the social worker wearing?' (Resident #37) stated, 'She was wearing blue...the blue uniform. Wait, well that is what the aides wear!!!? Maybe they were lying to me!? But I told someone who I thought was a social worker.'"

ASM #1 provided a statement signed by LPN (licensed practical nurse) #4 (unit manager) (no date) that documented, "Writer spoke to Aide (name of accused CNA) regarding guest (room number) stating he was doing this to her roommate (room number). Aide and others interviewed, (name of accused CNA and name of another CNA) always went in room together because of (Resident #37's) statements. (Name of accused CNA) was taken out of that room for his safety and most of the aides go in (room number) in two's."

ASM #1 provided a statement signed by LPN #4 and dated 2/14/19 that documented, "Son requested his mother be moved because of the nasty things (Resident #37) was saying to guest and family."
ASM #1 confirmed the allegation was not reported to the state agency or other officials because of the nature of the allegation and because the facility investigation was completed and the allegation was unfounded within the required time frame for reporting.

On 3/13/19 at 5:42 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 21	F 607		

director of operations) were made aware of the above concern. ASM #1 was asked to provide any further information to evidence a complete and thorough investigation was completed.

On 3/14/19 at 11:46 a.m., a telephone interview was conducted with OSM (other staff member) #2 (the former social worker). OSM #2 stated she did not remember the details regarding Resident #37's allegation that Resident #87 was raped. OSM #2 stated she remembered that Resident #37 stated the CNA came in the room but she didn't actually see anything happen. OSM #2 stated Resident #37 said things like the CNAs head was at Resident #87's "titty" level. OSM #2 stated she asked Resident #37 if she saw the CNA touch Resident #87 and Resident #37 said she did not see the CNA do anything but what else would the CNA have been doing down there. OSM #2 stated she documented what she heard from Resident #37, gave the document to the administrator, called the psychiatrist and separated Resident #37 from her roommate (Resident #87).

The facility policy titled, "ABUSE PROHIBITION, INVESTIGATION, AND REPORTING" documented, "It is the policy of this facility to prohibit mistreatment, neglect, and abuse of guests/residents and/or misappropriation of guest/ resident property or resources. The facility shall not allow verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion, or exploitation and all facility personnel with promptly report any incident or suspected incident of guest mistreatment, injuries of unknown source or misappropriation of property/resources. Reports of alleged abuse and/or misappropriation will be immediately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 607	Continued From page 22	F 607		

reported to the Administrator and thoroughly investigated. Allegations of abuse/misappropriation and the investigative conclusion will be reported to the appropriate State regulatory agency, Law Enforcement agency, licensing, and/or certification board as required by State and Federal law...III. Investigation: A. The person(s) observing an incident of guest abuse or suspecting guest abuse must immediately report such incidents/suspicions to the Administrator. If the Administrator is not immediately available, the allegation should be reported to a charge nurse, social worker, or nursing administration to ensure that the guest is safe. The supervisor/management person in charge will then immediately notify the Administrator. When an incident of guest abuse is alleged, the incident must be reported to the charge nurse regardless of the time lapse since the incident occurred. The following information should be reported: 1. The name of the guest. 2. The date and time that the incident occurred. 3. The location of the incident. 4. The name(s) of the person(s) committing the incident, if known. 5. The name(s) of any witness (es) to the incident. 6. The type of abuse that was committed (e.g. verbal, physical, sexual, misappropriation, etc.). 7. Other information that may be requested. B. Upon receiving a report of abuse, the charge nurse will immediately examine the guest. If any injuries are identified, the charge nurse will notify the physician and administer treatment as ordered. The findings of the examination will be recorded in the medical record (The physician is to be notified timely even if no injuries are observed). C. Appropriate actions must be taken immediately to protect the guest and others who could be affected while the investigation is in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 23	F 607		

progress. Accused individuals will be denied unsupervised access to the guest. If the allegation involves a family member of other visitor, visits may be made only in designated areas approved by the Administrator. Facility employees who have been accused of guest abuse will be suspended until the results of the investigation have been reviewed by the Administrator. D. The Administrator will appoint a representative to investigate the incident. The Administrator will initiate the Investigation of Alleged Abuse, Mistreatment, or Misappropriation and make the appropriate notifications as outlined on the form. E. The Administrator or designee will coordinate an immediate investigation in accordance with the investigation guidelines in this policy. The representative in charge of the investigation will consult with the Administrator daily concerning the progress of the investigation. A copy of the findings will be provided to the Administrator within five (5) working days of the occurrence of the incident. The investigation may consist of but is not limited to: 1. An interview with the person(s) reporting the incident. 2. Interviews with any witnesses to the incident. 3. An interview with the guest. 4. A review of the guest's medical record. 5. An interview with staff members (on all shifts) who had contact with the guest during the period of the alleged incident. 6. Interviews with the guest's roommate, family members, and visitors. 7. Physical assessment of other potentially affected guests. 8. A review of all circumstances surrounding the incident...IV. Initial Reporting: A. All allegations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property must be reported immediately to the Administrator...B. All phases of the reporting process will be kept confidential. C. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 24	F 607		

Administrator is responsible for ensuring that all allegations of mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are immediately reported to the State Agency and other officials in accordance with federal regulations and state guidelines. i. Allegations of abuse or serious bodily injury: If the event that caused the allegation involves an allegation of abuse or serious bodily injury, it should be reported to the state immediately, but no later than two (2) hours after the allegation is made...IV. Final Reporting: A. The findings of the investigation must be submitted to the state agency within five (5) working days of the allegation..."

No further information was presented prior to exit.

2. The facility staff failed to implement the abuse policy for reporting a resident-to-resident altercation when Resident # 89 received a scratch under their eye on 12/07/18. The incident was not reported to the State Agency until 12/10/18.

Resident # 89 was admitted to the facility on 01/08/2018 and a readmission on 06/05/2018 with diagnoses that included but were not limited to peripheral vascular disease (1), atherosclerosis (2) and hypertension (3).

Resident # 89's most recent comprehensive MDS (minimum dada set) a significant change assessment with an ARD (assessment reference date) of 02/19/19 coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact for daily decision making. Resident # 89 was coded

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 25	F 607		

as requiring supervision and set up for activities of daily living and independent with eating.

The facility's "Facility reported Incident (FRI)" documented, "Report Date: 12/10/18. Incident Date: 12/7/18. Residents involved: (Name of Resident # 2) and (Name of Resident # 89). Injuries: Yes. Scratch under eye of (Name of Resident # 89). Area cleaned. No treatment needed." Under the heading "Describe incident, including location and action taken" it documented, "Nurse entered room to find both guests striking and yelling at each other. Striking was initiated by (Name of Resident # 2) who also slid out of WC (wheelchair) when he rolled into (Name of Resident # 89). (Name of Resident # 2) removed from room. Q (every) 15 minutes checks initiated on both guest." Further review of the facility's FRI revealed documentation that the responsible party and physician were notified on "12/7/18." Review of the facility's facsimile "Send Result Report" attached to the FRI documented, "To: (Name of Person), Dept (department) of Health. (Name of Person), Ombudsman, (Name of Person), APS (Adult Protective Services). From: (Name of Nursing Home). Date: 12/10/18."

On 03/14/19 at 4:40 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the reporting procedure of a (facility reported incident) FRI to the Office of Licensure and Certification, ASM # 2 stated, "It's reported within two hours of the incident and the complete investigation within five days of the incident." After review the facility's FRI with the incident date of 12/07/18 regarding Resident # 89, ASM # 2 was asked if the FRI was submitted to the state

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 607	Continued From page 26 agency within the correct time frame. ASM # 2 stated, "No. The staff failed to notify me or the administrator until the tenth (12/10/18)." When asked to describe the procedure for reporting, ASM # 2 stated, "It's the staff's responsibility to notify us, myself or the administrator immediately and if we are not in the building they are to notify the on-call manager immediately." On 03/14/19 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, regional director of operations, and ASM # 4, regional clinical coordinator were made aware of the findings. No further information was provided prior to exit.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 609	Continued From page 27 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report allegations of abuse within the required time frame for two of 53 residents in the survey sample, Residents #87 and #89. 1. On 2/14/19 Resident #37 reported an allegation that an employee had raped Resident #87. The facility staff failed to report this allegation to the state agency and other agencies according to law. 2. The facility staff failed to ensure timely reporting to the State Agency and other officials in accordance with state law when Resident # 89 received a scratch under their eye on 12/07/18 during a resident to resident altercation. The incident was not reported until 12/10/18. The findings include: 1. On 2/14/19 Resident #37 reported an allegation that an employee had raped Resident #87. The facility staff failed to report this allegation to the state agency and other agencies according to law.	F 609	1. Resident #37 has not made any additional allegations of abuse. Resident #89 has not had any additional resident to resident altercations. 2. All residents have the potential to be affected by these alleged deficient practices. 3. All staff will be retrained on the abuse policy, reporting guidelines, and completing thorough investigations including what to do if a resident makes an allegation of abuse or a resident to resident altercation occurs. 4. All grievances will be reported to the facility grievance officer or designee when first identified/reported. Facility grievance officer will monitor all investigations for thoroughness and to ensure appropriate and timely reporting has occurred. Facility will interview 30 residents and 30 resident representatives for the next 2 quarters to ensure that no abuse or resident to resident altercations have occurred without facility knowledge. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 609	Continued From page 28 Resident #37 was admitted to the facility on 8/4/18. Resident #37's diagnoses included but were not limited to high blood pressure, major depressive disorder and delusional disorders. Resident #37's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/30/19, coded the resident as being cognitively intact. Section G coded Resident #37 as requiring extensive assistance of one staff with bed mobility, toilet use and personal hygiene. Resident #87 was admitted to the facility on 8/31/18. Resident #87's diagnoses included but were not limited to diabetes, high blood pressure and a fractured right arm. Resident #87's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/28/19, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #87 as requiring extensive assistance of one staff with bed mobility, toilet use and personal hygiene. On 3/12/19 at 1:53 p.m., an interview was conducted with Resident #37. Resident #37 stated the facility CNAs (certified nursing assistants) were abusive. Resident #37 stated within the last couple of months, that a CNA was in bed with Resident #87 (former roommate). Resident #37 stated the CNA's head was at the level of Resident #87's "titties." Resident #37 stated the CNA was raping Resident #87. When asked if she had reported this information to the facility staff, Resident #37 stated she reported this to the social worker, a nurse and a CNA. On 3/12/19 at 2:08 p.m. (immediately after the	F 609	will be monitored as part of the facility's QA process for 6 months. 5. Corrective action will be completed by 4/26/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 29 interview with Resident #37), the above allegation was reported to ASM (administrative staff member) #1 (the administrator). ASM #1 stated he was aware of the allegation and would provide additional information. ASM #1 was asked to provide evidence that the state agency and other officials were notified regarding the allegation. On 3/13/19 at 4:06 p.m., an interview was conducted with ASM #1. ASM #1 stated on 2/14/19 Resident #37 reported an allegation of rape to the former social worker after Resident #37 was told she was getting a new roommate. ASM #1 stated the social worker interviewed Resident #37 and Resident #37 stated she did not witness the rape but Jesus told her. ASM #1 stated the unit manager interviewed the CNA who allegedly raped Resident #87 and interviewed the resident's son who did not have any concerns. When asked if other staff was interviewed or if Resident #87 was assessed after Resident #37 voiced the allegation, ASM #1 stated Resident #37 stated the alleged rape occurred less than a month after that date but could not remember a date or time. ASM #1 confirmed the allegation was not reported to the state agency or other officials because of the nature of the allegation and because the facility investigation was completed and the allegation was unfounded within the required time frame for reporting. On 3/13/19 at 5:42 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of operations) were made aware of the above concern. ASM #1 was asked to provide any further information to evidence a complete and thorough investigation was completed.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 30 The facility policy titled, "ABUSE PROHIBITION, INVESTIGATION, AND REPORTING" documented, "It is the policy of this facility to prohibit mistreatment, neglect, and abuse of guests/residents and/or misappropriation of guest/ resident property or resources. The facility shall not allow verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion, or exploitation and all facility personnel with promptly report any incident or suspected incident of guest mistreatment, injuries of unknown source or misappropriation of property/resources. Reports of alleged abuse and/or misappropriation will be immediately reported to the Administrator and thoroughly investigated. Allegations of abuse/misappropriation and the investigative conclusion will be reported to the appropriate State regulatory agency, Law Enforcement agency, licensing, and/or certification board as required by State and Federal law...IV. Initial Reporting: A. All allegations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property must be reported immediately to the Administrator...B. All phases of the reporting process will be kept confidential. C. The Administrator is responsible for ensuring that all allegations of mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are immediately reported to the State Agency and other officials in accordance with federal regulations and state guidelines. i. Allegations of abuse or serious bodily injury: If the event that caused the allegation involves an allegation of abuse or serious bodily injury, it should be reported to the state immediately, but no later than two (2) hours after the allegation is	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 31	F 609		

made...IV. Final Reporting: A. The findings of the investigation must be submitted to the state agency within five (5) working days of the allegation..."

No further information was presented prior to exit.
2. The facility staff failed to ensure timely reporting to the State Agency and other officials in accordance with state law when Resident # 89 received a scratch under their eye on 12/07/18 during a resident to resident altercation. The incident was not reported until 12/10/18.

Resident # 89 was admitted to the facility on 01/08/2018 and a readmission on 06/05/2018 with diagnoses that included but were not limited to peripheral vascular disease (1), atherosclerosis (2) and hypertension (3).

Resident # 89's most recent comprehensive MDS (minimum dada set) a significant change assessment with an ARD (assessment reference date) of 02/19/19 coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact for daily decision making. Resident # 89 was coded as requiring supervision and set up for activities of daily living and independent with eating.

The facility's "Facility reported Incident (FRI)" documented, "Report Date: 12/10/18. Incident Date: 12/7/18. Residents involved: (Name of Resident # 2) and (Name of Resident # 89). Injuries: Yes. Scratch under eye of (Name of Resident # 89). Area cleaned. No treatment needed." Under the heading "Describe incident, including location and action taken" it documented, "Nurse entered room to find both guests striking and yelling at each other. Striking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 32	F 609		

was initiated by (Name of Resident # 2) who also slid out of WC (wheelchair) when he rolled into (Name of Resident # 89). (Name of Resident # 2) removed from room. Q (every) 15 minutes checks initiated on both guest." Further review of the facility's FRI revealed documentation that the responsible party and physician were notified on "12/7/18." Review of the facility's facsimile "Send Result Report" attached to the FRI documented, "To: (Name of Person), Dept (department) of Health. (Name of Person), Ombudsman, (Name of Person), APS (Adult Protective Services). From: (Name of Nursing Home). Date: 12/10/18."

On 03/14/19 at 4:40 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the reporting procedure of a (facility reported incident) FRI to the Office of Licensure and Certification, ASM # 2 stated, "It's reported within two hours of the incident and the complete investigation within five days of the incident." After review the facility's FRI with the incident date of 12/07/18 regarding Resident # 89, ASM # 2 was asked if the FRI was submitted to the state agency within the correct time frame. ASM # 2 stated, "No. The staff failed to notify me or the administrator until the tenth (12/10/18)." When asked to describe the procedure for reporting, ASM # 2 stated, "It's the staff's responsibility to notify us, myself or the administrator immediately and if we are not in the building they are to notify the on-call manager immediately."

On 03/14/19 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, regional director of operations, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 33 ASM # 4, regional clinical coordinator were made aware of the findings. No further information was provided prior to exit.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to complete a thorough abuse investigation for one of 53 residents in the survey sample, Resident #87. On 2/14/19, Resident #37 reported an allegation that an employee had raped Resident #87. The facility staff failed to conduct a complete and thorough investigation regarding this allegation.	F 610	1. Resident #37 has not made any additional allegations of abuse. 2. All residents have the potential to be affected by these alleged deficient practices. 3. All staff will be retrained on the abuse policy, reporting guidelines, and completing thorough investigations including what to do if a resident makes an allegation of abuse or a resident to resident altercation occurs.	4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 34 The findings include: Resident #37 was admitted to the facility on 8/4/18. Resident #37's diagnoses included but were not limited to high blood pressure, major depressive disorder and delusional disorders. Resident #37's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/30/19, coded the resident as being cognitively intact. Section G coded Resident #37 as requiring extensive assistance of one staff with bed mobility, toilet use and personal hygiene. Resident #87 was admitted to the facility on 8/31/18. Resident #87's diagnoses included but were not limited to diabetes, high blood pressure and a fractured right arm. Resident #87's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/28/19, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #87 as requiring extensive assistance of one staff with bed mobility, toilet use and personal hygiene. On 3/12/19 at 1:53 p.m., an interview was conducted with Resident #37. Resident #37 stated the facility CNAs (certified nursing assistants) were abusive. Resident #37 stated that within the last couple of months, a CNA was in bed with Resident #87 (former roommate). Resident #37 stated the CNA's head was at the level of Resident #87's "titties." Resident #37 stated the CNA was raping Resident #87. When asked if she had reported this information to the facility staff, Resident #37 stated she reported this to the social worker, a nurse and a CNA.	F 610	4. All grievances will be reported to the facility grievance officer or designee when first identified/reported. Facility grievance officer will monitor all investigations for thoroughness and to ensure appropriate and timely reporting has occurred. Facility will interview 30 residents and 30 resident representatives for the next 2 quarters to ensure that no abuse has occurred without facility knowledge. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored as part of the facility's QA process for 6 months. 5. Corrective action will be completed by 4/26/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 35 On 3/12/19 at 2:08 p.m. (immediately after the interview with Resident #37), the above allegation was reported to ASM (administrative staff member) #1 (the administrator). ASM #1 stated he was aware of the allegation and would provide additional information. On 3/13/19 at 4:06 p.m., an interview was conducted with ASM #1. ASM #1 stated Resident #37 reported an allegation of rape to the former social worker after Resident #37 was told she was getting a new roommate. ASM #1 stated the social worker interviewed Resident #37 and Resident #37 stated she did not witness the rape but Jesus told her. ASM #1 stated the unit manager interviewed the CNA who allegedly raped Resident #87 and interviewed the resident's son who did not have any concerns. When asked if other staff was interviewed or if Resident #87 was assessed after Resident #37 voiced the allegation, ASM #1 stated Resident #37 stated the alleged rape occurred less than a month after that date but could not remember a date or time. When asked about the facility process for investigating a rape allegation, ASM #1 stated in this case, Resident #37 reported the alleged rape did not occur that day so staff reviewed past skin records and also noticed Resident #87 did not have a change in behavior. ASM #1 was not able to provide evidence that Resident #87 was assessed the day the allegation was reported. When asked to provide evidence that a complete investigation was completed, ASM #1 stated an interview was conducted with Resident #37 and Resident #87's son. ASM #1 stated Resident #87 did have a skin assessment on 2/13/19 (the day	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 610	Continued From page 36	F 610		

prior to the allegation). ASM #1 was asked to provide any further details to evidence a complete and through investigation was conducted. ASM #1 provided a typed document dated 2/14 (no year) that documented, "SW (Social Worker) notified (Resident #37) she is getting a new roommate. (Resident #37) stated, 'Why?' SW stated, 'your roommate's son has requested she be moved to another room' (Resident #37) stated, 'well does he know about (name of CNA)?' SW stated, 'What?' (Resident #37) stated, 'He got in the bed with her and raped her!' SW informed DON (Director of Nursing) and Administrator of what guest said. Administrator asked SW to investigate this more and get details from guest. SW went back to room and spoke with (Resident #37) about the situation. (Resident #37) stated, 'It was less than a month ago- I can't remember the day or time.' SW asked if guest knew if it was morning or night. (Resident #37) stated, 'Well it would have had to have been day because (name of CNA) works days.' (Resident #37) stated, 'The curtain was pulled so I could see half of (Resident #87). I saw (name of CNA) was lying in bed with her. He was on his left side facing her and I could see the back of his head. His head was not at the same level as her head. His head was at her titty. He was sucking on her titty.' (Resident #37) then stated, 'Then he fucked her.' SW asked guest if she actually saw this happen. (Resident #37) stated, 'Well, no, cause I could only see the half of them, but, the Lord Jesus told me he fucked her.' SW asked if guest said anything during all this. (Resident #37) stated, 'Well (Resident #87) has the dementia ya know.' SW stated she is aware that (Resident #87) has a dx (diagnosis) of dementia, but reiterated the question to (Resident #37), 'Did (Resident #87) say anything during this.' (Resident #37) stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 610	Continued From page 37	F 610		

'No, she just laid there.' (Resident #37) then stated, 'Well I told the other social worker about this.' SW stated, 'What other social worker?' (Resident #37) stated, 'The black one.' SW stated, '(Resident #37), we had a black social worker over a year ago, but not recently.' (Resident #37) stated, 'Well this was the night before last.' SW asked, 'What was the social worker's name? Did she identify herself as a social worker?' (Resident #37) stated, 'No, one of the aides told me.' SW stated, 'What aide?' (Resident #37) stated, 'Well one of the ones around was (name)...but I'm not sure she told me. One of the aides told me this person was a social worker but I'm not sure who.' SW asked, 'What was the social worker wearing?' (Resident #37) stated, 'She was wearing blue...the blue uniform. Wait, well that is what the aides wear!!!? Maybe they were lying to me!? But I told someone who I thought was a social worker.'"

ASM #1 provided a statement signed by LPN (licensed practical nurse) #4 (unit manager) (no date) that documented, "Writer spoke to Aide (name of accused CNA) regarding guest (room number) stating he was doing this to her roommate (room number). Aide and others interviewed, (name of accused CNA and name of another CNA) always went in room together because of (Resident #37's) statements. (Name of accused CNA) was taken out of that room for his safety and most of the aides go in (room number) in two's." ASM #1 provided a statement signed by LPN #4 and dated 2/14/19 that documented, "Son requested his mother be moved because of the nasty things (Resident #37) was saying to guest and family."

On 3/13/19 at 5:42 p.m., ASM (administrative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 38	F 610		

staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of operations) were made aware of the above concern. ASM #1 was asked to provide any further information to evidence a complete and thorough investigation was completed.

On 3/14/19 at 11:46 a.m., a telephone interview was conducted with OSM (other staff member) #2 (the former social worker). OSM #2 stated she did not remember the details regarding Resident #37's allegation that Resident #87 was raped. OSM #2 stated she remembered that Resident #37 stated the CNA came in the room but she didn't actually see anything happen. OSM #2 stated Resident #37 said things like the CNAs head was at Resident #87's "titty" level. OSM #2 stated she asked Resident #37 if she saw the CNA touch Resident #87 and Resident #37 said she did not see the CNA do anything but what else would the CNA have been doing down there. OSM #2 stated she documented what she heard from Resident #37, gave the document to the administrator, called the psychiatrist and separated Resident #37 from her roommate (Resident #87).

The facility policy titled, "ABUSE PROHIBITION, INVESTIGATION, AND REPORTING" documented, "It is the policy of this facility to prohibit mistreatment, neglect, and abuse of guests/residents and/or misappropriation of guest/ resident property or resources. The facility shall not allow verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion, or exploitation and all facility personnel with promptly report any incident or suspected incident of guest mistreatment, injuries of unknown source or misappropriation of

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 610	Continued From page 39	F 610		

property/resources. Reports of alleged abuse and/or misappropriation will be immediately reported to the Administrator and thoroughly investigated. Allegations of abuse/misappropriation and the investigative conclusion will be reported to the appropriate State regulatory agency, Law Enforcement agency, licensing, and/or certification board as required by State and Federal law...III. Investigation: A. The person(s) observing an incident of guest abuse or suspecting guest abuse must immediately report such incidents/suspicions to the Administrator. If the Administrator is not immediately available, the allegation should be reported to a charge nurse, social worker, or nursing administration to ensure that the guest is safe. The supervisor/management person in charge will then immediately notify the Administrator. When an incident of guest abuse is alleged, the incident must be reported to the charge nurse regardless of the time lapse since the incident occurred. The following information should be reported: 1. The name of the guest. 2. The date and time that the incident occurred. 3. The location of the incident. 4. The name(s) of the person(s) committing the incident, if known. 5. The name(s) of any witness (es) to the incident. 6. The type of abuse that was committed (e.g. verbal, physical, sexual, misappropriation, etc.). 7. Other information that may be requested. B. Upon receiving a report of abuse, the charge nurse will immediately examine the guest. If any injuries are identified, the charge nurse will notify the physician and administer treatment as ordered. The findings of the examination will be recorded in the medical record (The physician is to be notified timely even if no injuries are observed). C. Appropriate actions must be taken

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

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F 610	Continued From page 40 immediately to protect the guest and others who could be affected while the investigation is in progress. Accused individuals will be denied unsupervised access to the guest. If the allegation involves a family member of other visitor, visits may be made only in designated areas approved by the Administrator. Facility employees who have been accused of guest abuse will be suspended until the results of the investigation have been reviewed by the Administrator. D. The Administrator will appoint a representative to investigate the incident. The Administrator will initiate the Investigation of Alleged Abuse, Mistreatment, or Misappropriation and make the appropriate notifications as outlined on the form. E. The Administrator or designee will coordinate an immediate investigation in accordance with the investigation guidelines in this policy. The representative in charge of the investigation will consult with the Administrator daily concerning the progress of the investigation. A copy of the findings will be provided to the Administrator within five (5) working days of the occurrence of the incident. The investigation may consist of but is not limited to: 1. An interview with the person(s) reporting the incident. 2. Interviews with any witnesses to the incident. 3. An interview with the guest. 4. A review of the guest's medical record. 5. An interview with staff members (on all shifts) who had contact with the guest during the period of the alleged incident. 6. Interviews with the guest's roommate, family members, and visitors. 7. Physical assessment of other potentially affected guests. 8. A review of all circumstances surrounding the incident..." No further information was presented prior to exit.	F 610		
F 622	Transfer and Discharge Requirements	F 622		4/26/19

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 622 SS=D	Continued From page 41 CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

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F 622	Continued From page 42 discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information	F 622		

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F 622	Continued From page 43 (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to evidence that all required information, including comprehensive care plan goals, was provided to the receiving hospital when one of 53 residents in the survey sample, Resident #20, was transferred to the hospital on 12/17/18 and 12/24/18. The facility staff failed to provide the receiving hospital with the Resident #20's comprehensive care plan goals during a facility initiated transfer to the hospital on 12/17/18 and 12/24/18. The findings include: Resident #20 was admitted to the facility on 5/16/18 with a recent with diagnoses that included but were not limited to, heart failure, sleep apnea [a condition in which the patient has transient periods of apnea during sleep (1)], obesity, diabetes and depression. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 1/10/19, coded the resident as scoring a "15" on the BIMS	F 622	1. Resident #20 has returned to the facility. 2. All residents have the potential to be affected by this alleged deficient practice. 3. The DON or designee will educate nursing staff on proper discharge documentation to provide to the receiving hospital. 4. The DON or designee will review 5 times weekly all residents transferred to the hospital for 4 weeks. Review will include ensuring care plan goals have been provided to receiving hospital. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 622	Continued From page 44	F 622		

(brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of two or more staff members for her toileting needs.

The nurse's note dated, 12/17/18, at 2:31 p.m. documented, "Resident lethargic and speech garbled. Friend called facility and stated he visited yesterday and 'thinks she should be sent to the ER [emergency room]. RP (responsible party) #1 called and notified of residents condition and agreed with sending her to the hospital. NP (nurse practitioner) over to see and gave order to send her to (Name of hospital) ER. VS (vital signs) 98.1 (temperature) 108 (heart rate) 20 (respirations) 125/85 (blood pressure) O2 (oxygen) sat (saturation level) 99% on Bipap [Bi - PAP, bi-level Positive Airway Pressure, is a machine used to assist people who are diagnosed with sleep apnea. Bi Pap machine can be set for breathing in and breathing out pressure settings (2)]. Resident sent to (name of hospital) ER for eval (evaluation) via 911 (emergency medical services). Report called to ER nurse. Transfer form, Bed hold policy and med (medication) list sent with EMTs (emergency medical technicians)."

The nurse's note dated, 12/24/18 at 2:53 a.m. documented in part, "Guess (sic) had a sudden change in respiratory breathing. Woke yelling for help. On entering room to observe (sic) Guess (sic) greatly heaving for breath and struggling to breath. Immediate called other nurses to room. Obtain VS (vital signs), hooked Guess (sic) to O2 (oxygen) tan with rebreather mask. O2 sats (saturations) had dropped into 70/80, with mask on and increase O2 to 4L (liters per minute). Sats

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

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F 622	Continued From page 45 rose to 98%, not maintaining. But Guess (sic) respiration not improved, labored and heavy struggling to breathe. Nurse called for emergency squad. Transporting Guesss (sic) to (initials of hospital) ER (emergency room). Report to on call MD (medical doctor) and called RR (resident representative)." Review of the "Nursing Home to Hospital Transfer Form" failed to evidence documentation that the care plan goals were sent to the hospital for the residents facility initiated transfers on 12/17/18, or on 12/24/18. The "eInteract" Transfer Form" dated, 12/17/18, and 12/24/18, failed to evidence documentation that the care plan goals were sent to the hospital with the resident on 12/17/19 or 12/24/19. An interview was conducted with LPN (licensed practical nurse) #1, on 3/14/19 at 1:56 p.m., regarding what documents are provided to the hospital for a facility initiated transfer of a resident to the hospital. LPN #1 stated, "The bed hold policy, MARS (medication administration record), eInteract form, change in condition papers, care plan, my note." When asked where what information was sent with the resident is documented, LPN #1 stated, "We have to do a transfer note in the clinical record after we send the resident out." Review of the clinical record failed to evidence a "Transfer Note" for 12/17/18 or 12/24/18. An interview was conducted with RN (registered Nurse) #1, the assistant director of nursing, on 3/14/19 at 2:31 p.m. what information is sent with	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 622	Continued From page 46 a resident for a facility initiated transfer to the hospital. RN #1 stated, "We prepare the care plan goals, the face sheet, recent laboratory tests, recent x-ray results, we try to send the H&P (history and physical) or the last progress note from the MD (medical doctor). We send the copy of the MAR/TAR (medication administration record/treatment administration record), bed hold policy, transfer notice." When asked where it is documented that all of these documents went to the hospital, RN #1 stated, "The nurse writes a transfer note documenting what documents were sent." The clinical record was reviewed with RN #1 for Resident #20's hospital transfer on 12/17/18 and 12/24/18. RN #1 stated she didn't see the note. RN #1 requested to go and look to see what she could find. She stated she thinks the nurses copy the papers sent to the hospital. RN #1 returned to this surveyor at 4:15 p.m. and stated she could not find any documentation of what information was sent to the hospital except what was documented above. A request was made on 3/14/19 at approximately 5:30 p.m. for a copy of the policy for admissions, transfers and discharges. Administrative staff member (ASM) #1, the administrator and ASM # 3, the regional director of operations, we made aware of the above concern on 3/14/19 at 4:33 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 534. (2) This information was obtained from the following website:	F 622		

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 622	Continued From page 47 www.webmd.com/sleep-disorders/sleep-apnea.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623		4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 623	Continued From page 48 (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 623		

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 623	Continued From page 49 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility staff failed to provide written notification to the resident and/or resident representative and/or ombudsman of a facility initiated transfer for two for 53 residents in the survey sample, Residents #20 and #50. 1. The facility staff failed to provide written notification to Resident #20 or the responsible representative for the 12/17/18 and 12/24/18 facility initiated transfers to the hospital. 2. The facility staff failed to provide evidence that the Ombudsman was provided written notification of Resident #50's facility initiated transfer to the hospital on 1/14/19. The findings include:	F 623	1. Resident #20 has returned to the facility. Resident #50 no longer resides at the facility, but the Ombudsman has been notified of the hospital transfer. 2. All residents have the potential to be affected by this alleged deficient practice. 3. The DON or designee will educate nursing staff on proper discharge documentation to provide to the resident or resident representative. The administrator will educate the social worker on the facility's discharge policies including ombudsman notification. The social worker will provide regular written notification to the ombudsman regarding when the discharges are initiated by the facility. Once a month, the social worker will identify all residents discharged and	

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

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F 623	Continued From page 50 1. The facility staff failed to provide written notification to Resident #20 or the responsible representative for the 12/17/18 and 12/24/18 facility initiated transfers to the hospital. Resident #20 was admitted to the facility on 5/16/18 with diagnoses that included but were not limited to, heart failure, sleep apnea [a condition in which the patient has transient periods of apnea during sleep (1)], obesity, diabetes and depression. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 1/10/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of two or more staff members for her toileting needs. The nurse's note dated, 12/17/18 at 2:31 p.m. and 12/24/18 at 2:53 a.m., documented, Resident #20 was transferred to a local hospital on theses dates. Review of the clinical record failed to evidence written notification of the transfers to the hospital on 12/17/18 and 12/24/18 was provided to Resident #20 and/or responsible representative. An interview was conducted with LPN (licensed practical nurse) #1 on 3/14/19 at 1:56 p.m. When asked if written notification is provided to the resident or resident's responsible representative regarding why the resident was transferred to the hospital, LPN #1 stated, "We call the family. I	F 623	will provide a discharge resident list to the ombudsman including reasons for transfers. 4. DON or designee will review 5 times weekly all residents transferred to the hospital for 4 weeks. Review will include ensuring transfer notice has been provided to resident and/or resident representative. NHA will monitor ombudsman notifications have been completed by social worker monthly. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 623	Continued From page 51 don't mail anything to anyone." An interview was conducted with RN (registered nurse) #1 on 3/14/19 at 2:31 p.m. When asked if written notification is provided to the resident or resident's responsible representative regarding why the resident was transferred to the hospital, RN #1 stated, "If the family member is in the building, we tell them. If they are not here in the building, we call them. RN #1 stated the transfer notice goes to the family, we provide a copy with the guest and it goes to the hospital." When asked for the location in the clinical record documenting this written notice being given to the resident and/or resident representative, RN #1 stated, "I don't see it. It would be in a transfer note." Review of the clinical record failed to evidence a "Transfer Note" for Resident #20's facility initiated hospital transfers on 12/17/18 and 12/24/18. A request was made on 3/14/19 at approximately 5:30 p.m. for a copy of the policy for admissions, transfers and discharges. Administrative staff member (ASM) #1, the administrator and ASM # 3, the regional director of operations, we made aware of the above concern on 3/14/19 at 4:33 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 534. (2) This information was obtained from the following website:	F 623		

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F 623	Continued From page 52 www.webmd.com/sleep-disorders/sleep-apnea. 2. The facility staff failed to provide evidence that the Ombudsman was provided written notification of Resident #50's facility initiated transfer to the hospital on 1/14/19. Resident #50 was admitted to the facility on 1/9/19 with the diagnoses of but not limited to Adult Failure to Thrive, Pneumonia, Dysphagia, Type 2 Diabetes, high blood pressure, Stroke, hemiplegia and hemiparesis on right side, gastro-esophageal reflux disease. Resident #50's MDS (minimum data set) was an admission assessment with an Assessment Reference Date (ARD) of 1/17/19. Resident #50 was coded as moderately cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note on 1/14/19 at 4:28 PM, documented the following: "Transfer form: document given to paramedics. Notification of transfer: was provided to MD (Medical Doctor), family: guardian, and paramedics. Bed hold policy: provided to paramedics. Medications: MAR provided to paramedics. Care Plan Goals: provided to paramedics." A review of the clinical record revealed a nurse's note on dated 1/16/19 that documented, "Late entry from 1/14/19: Guest sent out to ER (emergency room) for critical labs (laboratory test) results; guest left for (name of one hospital), but was diverted to (name of a second hospital). MD aware." A review of the clinical record failed to reveal any	F 623		

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F 623	Continued From page 53 evidence that the Ombudsman was provided with notification of the hospital transfer. On 3/13/19 at 5:18 p.m., an interview with OSM # 3 (Other Staff Member) (Social Worker) was conducted. When asked if the Ombudsman is notified of a resident's facility initiated transfer, OSM #3 stated, "We only send an end of the month report. I will need to go to someone else's office to get her book and will bring the January report to the conference room." On 3/13/19 at 5:39 p.m., OSM #3 provided the January 2019, Ombudsman notification report, which did not reveal Resident #50's name. When asked if Resident #50 should be included in the report, OSM #3 stated, "If they are going to the ER, we do not send a notification to the Ombudsman." On 3/14/19 at approximately 3:15 p.m., the policy for Ombudsman notification for residents being transferred or discharged from the facility was requested. On 3/14/19 at approximately 5:00 p.m., in a follow up interview with OSM # 3, regarding the policy for Ombudsman notification, she stated. "There were no policies regarding hospital transfers and Ombudsman notification." On 3/14/19 at approximately 3:30 p.m., ASM #1 (Administrative Staff Member) (Administrator) and ASM #3 (Regional Director of Operations) were made aware of the findings. No further information was provided by the end of the survey.	F 623		
F 655	Baseline Care Plan	F 655		4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 655 SS=D	Continued From page 54 CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and	F 655		

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 655	Continued From page 55 dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to update a baseline care plan for one of 53 residents in the survey sample, Resident # 53. The facility staff failed to update Resident # 53's baseline care plan concerning a fall on 02/11/19. The findings include: The facility staff failed to update Resident # 53's baseline care plan concerning a fall on 02/11/19. Resident # 53 was admitted to the facility on 02/08/19 with diagnoses that included but were not limited to: muscle weakness, abnormalities of gait and mobility, cerebral infarction (1), aphasia (2), and hypertension (3). Resident # 53s most recent comprehensive MDS (minimum dada set) an admission assessment with an ARD (assessment reference date) of 02/15/19 coded the resident as scoring a 99 on the brief interview for mental status (BIMS) of a score of 0 - 15, 99 coded Resident # 53 as being unable to complete the brief interview for mental status. Under "Staff Assessment for Mental Status" Resident # 53 was coded a 2 (two), moderately impaired of cognition for daily decision making. Resident # 53 was coded as	F 655	1. Resident #53's care plan has been updated and addresses falls. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All licensed nursing staff will be educated on facility baseline care plan policy, including updating baseline care plans with identified interventions related to falls. 4. MDS coordinator or designee will conduct audits of the baseline care plans 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure that care plans are being updated with identified fall interventions. Monitoring will include tracking and trending of issues found during the audits. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 655	Continued From page 56	F 655		

requiring extensive assistance of one staff member for activities of daily living and totally dependent of one staff member for eating. Under section J1900 "Number of Falls Since Admission/Entry or Reentry or Prior Assessment, whichever is more recent" coded Resident # 53 as having two or more falls with no injury.

The facility's "Progress Notes" dated "2/11/2019" for Resident # 53 documented, "Nurse was called in room that guest has fallen out of his bed. Upon arrival, guest was lying face down and was returned to bed. Guest checked by the nurse and no injury noted, no cut, no knot noted. Neuro (neurological) checks initiated and are WNL (within normal limits). Guest was taken to the nurse's station and continue to propel self on the unit. VS (vital signs) = 96.2 (temperature), 65 (pulse), 16 (respiration), 134/67 (134 over 67 blood pressure), 99% (oxygen saturation). POA (power of attorney), MD (medical doctor) notified. Guest is up at the nurse's station at this time. Will monitor."

The facility's "Incident Report" dated 02/11/19 for Resident # 53 documented, Under "Post Incident Analysis" "Additional explanation as apparent: Guest restless and continues to pull at PEG tube. MD/NP (medical doctor/nurse practitioner) to address and review meds (medications)." Following this statement it documented, "The above intervention has been incorporated into the guest's care plan and into the Nursing Care Instruction card" and was signed by ASM (administrative staff member) # 2, the director of nursing with a date of "2/11/19."

The baseline care plan dated "2/8/19" for Resident # 53 was reviewed. Under

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 655	Continued From page 57	F 655		

"Falls/Safety/Elopement Risks/Devices" it documented, "2/8 (02/08/19). Evaluate for unsteady gait. 2/8. Orthostatic hypotension precautions. 2/8. Ambulation devices as necessary. 2/8. Instruct guest on appropriate safety measures. 2/8. Observe cognitive status for ability to ask for assistance. 2/8. Observe guest's footwear for fit and non-skid soles." Further review of the baseline care plan failed to evidence updates or reviews following Resident # 53's fall on 02/11/19.

On 03/14/19 at 10:13 a.m., an interview was conducted with RN (registered nurse) # 3, MDS coordinator. After reviewing the baseline care plan for Resident # 53 regarding the fall on 2/11/19, RN # 3 stated, "It (baseline care plan) should have been updated with intervention of the MD/NP to assess and review the medications. It's not on the care plan." When asked to describe the procedure for updating a resident's baseline care plan, RN # 3 stated, "When a resident falls the nurse is to implement an immediate intervention and it is communicated with management staff then IDT (interdisciplinary team) will meet to discuss falls and revise/update the care plan." When asked what policy they follow for updating the care plan, RN # 3 sated, "We follow the RAI (resident assessment instrument) manual."

On 02/15/19 at approximately 5:00 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked if the recommendations or the "Additional explanations" on an the facility incident report were not documented on the baseline care plan, could you say that the baseline care plan was reviewed, revised or updated ASM # 2 stated,

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 655	Continued From page 58 "No." On 03/14/19 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, regional director of operations, and ASM # 4, regional clinical coordinator were made aware of the findings. No further information was provided prior to exit. References: (1) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . (2) A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

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F 656	Continued From page 59 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 656	Continued From page 60 section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for two of 53 residents in the survey sample, Residents #36, and #50. 1. The facility staff failed to develop a care plan to address Resident #36's urinary incontinence. 2. The facility staff failed to develop a comprehensive care plan to include Resident #50's risk for altered nutritional status based on the triggered Care Area Assessment (CAA) Summary - Nutritional Status from the Minimum Data Set (MDS) Section V dated 1/17/19. The findings include: 1. The facility staff failed to develop a care plan to address Resident #36's urinary incontinence. Resident #36 was admitted to the facility on 3/5/15. Resident #36's diagnoses included but were not limited to diabetes, high blood pressure and difficulty swallowing. Resident #36's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/28/19, coded the resident's cognition as moderately impaired. Section H coded Resident #36 as occasionally incontinent of urine. Section V coded urinary incontinence as a triggered care area and documented urinary incontinence would be addressed in the care plan. Review of Resident #36's comprehensive	F 656	1. Resident #36□s care plan has been updated and addresses urinary incontinence. Resident #50 no longer resides in the facility. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All licensed nursing staff, dietary manager and dietician will be educated on facility care plan policy, including initiating interventions for residents with episodes of urinary incontinence or at are risk for altered nutritional status. 4. MDS coordinator or designee will conduct audits of the care plans 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure that any guest with urinary incontinence or are at risk for altered nutritional status as triggered by Nutritional Status CAA have care plans initiated. Monitoring will include tracking and trending of issues found during the audits. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility□s QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

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F 656	Continued From page 61	F 656		

care plan dated 1/24/18 failed to document information regarding urinary incontinence.

On 3/13/19 at 3:49 p.m., an interview was conducted with LPN (licensed practical nurse) #6 (MDS coordinator). LPN #6 confirmed there was no care plan to address Resident #36's urinary incontinence. When asked if there should be, LPN #6 stated, "Yes." LPN #6 stated Resident #36 was coded as being occasionally incontinent of urine. LPN #6 stated urinary incontinence triggered in the care area assessment and section V of the MDS documented the area would be care planned. LPN #6 stated the MDS coordinators reference the CMS (Centers for Medicare and Medicaid) RAI (Resident Assessment Instrument) manual when developing care plans based on triggered care areas.

On 3/13/19 at 5:42 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of operations) were made aware of the above concern.

The facility policy titled, "CARE PLAN" documented, "The Care Plan must be written and submitted by the attending physician prior to admission. Guests will not be admitted to this facility without a written care plan. The care plan will include: 1. Diagnoses, symptoms, complaints, and complications indicating the need for admission. 2. Description of the functional level of the individual. 3. Objectives and goals. 4. All appropriate orders (medications, treatments, activities, restorative services, diet, etc.). 5. Plans for continuing care. 6. Plans for discharge. The care plan and a written report of each

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

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F 656	Continued From page 62	F 656		

evaluation must be entered in the guest's medical record. The above data will be utilized in developing the guest's individual care plan."

The CMS RAI manual documented:
"SECTION V: CARE AREA ASSESSMENT (CAA) SUMMARY
Intent: The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences. Care Areas are triggered by MDS item responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning.
There are 20 CAAs in Version 3.0 of the RAI, which includes the addition of "Pain" and "Return to the Community Referral." These CAAs cover the majority of care areas known to be problematic for nursing home residents. The Care Area Assessment (CAA) process provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and directs facility staff and health professionals to evaluate triggered care areas.
The interdisciplinary team (IDT) then identifies relevant assessment information regarding the resident's status. After obtaining input from the resident, the resident's family, significant other, guardian, or legally authorized representative, the IDT decides whether or not to develop a care plan for triggered care areas."

2. The facility staff failed to develop a comprehensive care plan to include and address Resident #50's risk for altered nutritional status based on the triggered Care Area Assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 656	Continued From page 63 (CAA) Summary - Nutritional Status from the Minimum Data Set (MDS) Section V dated 1/17/19. Resident #50 was admitted to the facility on 1/9/19 with the diagnoses of but not limited to Adult Failure to Thrive, Pneumonia, Dysphagia, Type 2 Diabetes, high blood pressure, Stroke, hemiplegia and hemiparesis on right side, gastro-esophageal reflux disease. Resident #50's MDS was an admission assessment with an Assessment Reference Date (ARD) of 1/17/19. Resident #50 was coded as moderately cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for hygiene, dressing, toileting, transfers; setup and supervision for eating; and as always incontinent of bowel and bladder. Section V of the admission MDS documented Nutrition as a triggered care area. The MDS Section V trigger referred to the CAA Worksheet dated 1/24/19. A review of the CAA Worksheet dated 1/24/19, signed by RN #3 (MDS Coordinator), documented the following as Resident #50's problem/need: "Guest initially hospitalized d/t (due to) aspirational pneumonia and acute kidney injury, then discharged to SNF (Skilled Nursing Facility). While in hospital, guest was sent to hospital d/t abnormal labs (laboratory tests). Guest is chronically anemic, but required a blood transfusion. Guest requires supervision with eating and extensive assistance with all other ADLs (Activities of Daily Living)." Under the Care Plan Considerations section: "Will Nutritional Status - Functional Status be addressed in the care plan?" RN #3 documented the following: "Yes." "If care planning for this problem, what is	F 656		

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 656	Continued From page 64	F 656		

the overall objectives:?" RN #3 documented the following: "Improvement and minimize risks."

A review of the clinical record revealed the following weight log information for Resident #50. On 1/9/19, Resident #50's weight was recorded as 240.2 pounds. On 1/10/19, Resident #50's weight was recorded as 232.6 pounds using a mechanical lift. On 2/6/19, Resident #50's weight was recorded as 221.0 pounds using a mechanical lift. On 2/27/19, Resident #50's weight was recorded as 218.8 pounds.

A review of the clinical record revealed that on 1/9/19, the MD (Medical Doctor) ordered, "Consistent carbohydrate diet, regular texture, thin consistency, and cardiac."

A review of the clinical record revealed that on 1/11/19, the MD documented the following: "Review of Systems: Constitutional: Loss of appetite."

Further review of the clinical record revealed that on 2/5/19 at 3:00 p.m., the MD ordered, "Sugar free health shake every day and evening shift for supplement."

A review of the clinical record revealed the following information on the MAR (Medication Administration Record) for February 2019; Resident #50 refused the day shift sugar free health shake 10 times with no refusals for the evening shift administration. The MAR for March 2019 documented that Resident #50 refused the day shift sugar free health shake eight times with one refusal for the evening shift administration.

A review of the ADLs (Activities of Daily Living) for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

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F 656	Continued From page 65	F 656		

January 2019 - March 2019, revealed that Resident #50 ate 0 - 25% of the breakfast meals - 26 times; the lunch meals - nine times; the dinner meals - zero times. A review of the ADLs for January 2019 - March 2019, revealed that Resident #50 ate 26 - 50% of the breakfast meals - 16 times; the lunch meals - seven times; the dinner meals - three times. The ADLs for January 2019 - March 2019, revealed that Resident #50 refused 14 meals.

Further review of the clinical record revealed that on 3/5/19 at 8:32 p.m., the physician progress notes documented Resident #50's weight patterns as above.

A review of the care plan for Resident #50 dated 1/22/19 revealed no documentation for being at risk for altered nutritional status or any interventions to address the resident's weight loss.

On 3/14/19 at 2:10 p.m., an interview with RN #6 (Unit Manager) was conducted. When asked if the MDS Section V triggers a CAA trigger for nutrition, should a resident centered care plan be initiated for that care area, RN #6 stated, "Yes." When asked who is responsible for the initiation of a resident centered care plan, RN #6 stated, "I would say the MDS Coordinator or the nurse. Any nurse should be able to do a care plan." RN #6 reviewed Resident #50's care plan. After the review, RN #6 was asked if Resident #50's care plan reflected an area addressing the CAA triggered area for nutrition. RN #6 stated, "Cannot show it to you. The only thing I saw diet related is related to blood sugars but not nutrition." When asked if it should be care planned, when triggered on a CAA, RN #6 stated,

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 66 "I believe so, it should be." When asked if there was any issues with Resident #50's weight log, RN #6 stated, "Weight loss." When asked if Resident #50's care plan reflected the weight loss or addressed the resident's nutrition, RN #6 stated, "No." On 3/14/19 at approximately 2:40 p.m., an interview with RN #3 (MDS Coordinator) was conducted. When asked if the MDS Section V triggers a CAA (care area assessment) trigger for nutrition, should a resident centered care plan be initiated for that care area, RN #3 stated, "Yes." When asked who is responsible for the initiation of a resident centered care plan, RN #3 stated, "The team, the IDT (Interdisciplinary team) team. The nutritional care plan is developed by the dietitian." RN #3 reviewed Resident #50's care plan. After the review, RN #3 was asked where the care plan reflected an area addressing the CAA triggered area for nutrition. RN #3 stated, "I already audited it, if you go under the (the facility's electronic clinical record program), it is under the dehydration care plan. I updated it today (3/14/19) to include nutrition in the dehydration." When asked what prompted her to audit Resident #50's care plan. RN #3 stated that the facility identified Resident #50 as a resident that was being reviewed by the survey team and as a result of that, Resident #50 was identified as having not been care planned for nutrition and she added it to the dehydration care plan today (3/14/19). When asked if there was any issues with Resident #50's weight log, RN #3 stated, "Yes." RN #3 was asked if Resident #50 should have had a care plan in place prior to today to address nutrition and the resident's weight loss. RN #3 stated, "Yes."	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 67	F 656		

On 3/14/19 at 3:10 p.m., an interview with OSM #12 (Other Staff Member) (Registered Dietitian) was conducted. OSM #12 was asked if the MDS Section V triggers a CAA trigger for nutrition, should a resident centered care plan be initiated for that care area. OSM #12 stated, "With every resident, myself and my counterpart. Sounds like this resident (Resident #50) was not completed to the fullest. Every resident gets a care plan. I am always putting in a care plan for residents. That is best practices. That is typically, what we do. I don't know him (Resident #50) and I do not have (the facility's electronic clinical record program) in front of me. It is our practice to do a care plan, sounds like it was not completed and is an outlier and an issue. The assessment that was opened, (for Resident #50) and was not completed. I can assess him (Resident #50) in the morning. We do all components at the same time. Evaluations in (the facility's electronic clinical record program) and if it triggers a CAA, we do a care plan. If a resident has a weight loss or gain we do put it in the care plan and revise it."

According to the RAI manual dated October 2018 on page 4-1 documented, "Chapter 4: Care Area Assessment (CAA) Process and Care Planning - Section 4.1: Background and Rationale" revealed the following: " ...The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care." On page 4-32, "Section 4.10 - The Twenty Care Areas - 12. Nutritional Status" revealed the following: "The Nutritional Status CAA process reflects the need for an in-depth analysis of residents with impaired nutrition and those who

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 656	Continued From page 68 are at nutritional risk ...may also trigger based on loss of appetite with little or no accompanying weight loss and despite the absence of obvious, outward signs of impaired nutrition." On 3/14/19 at approximately 3:30 p.m., ASM #1 (Administrative Staff Member) (Administrator) and ASM #3 (Regional Director of Operations) were made aware of the findings. No further information was provided by the end of the survey.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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 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	F 657		4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 657	Continued From page 69 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that facility staff failed to review or revise the care plan for two of 53 residents in the survey sample, Resident # 53, and # 55. 1. The facility staff failed to update Resident # 53's comprehensive care plan concerning a fall on 02/15/19. 2. The facility staff failed to review and revise Resident #55's care plan to include oxygen administration. The findings include: 1. The facility staff failed to update Resident # 53's comprehensive care plan concerning a fall on 02/15/19. Resident # 53 was admitted to the facility on 02/08/19 with diagnoses that included but were not limited to: muscle weakness, abnormalities of gait and mobility, cerebral infarction (1), aphasia (2), and hypertension (3). Resident # 53s most recent comprehensive MDS (minimum dada set) an admission assessment with an ARD (assessment reference date) of 02/15/19 coded the resident as scoring a 99 on the brief interview for mental status (BIMS) of a score of 0 - 15, 99 coded Resident # 53 as being unable to complete the brief interview for mental status. Under "Staff Assessment for Mental	F 657	1. Resident #53's care plan has been updated and addresses falls. Resident #55's care plan has been updated and addresses oxygen administration. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All licensed nursing staff will be educated on facility care plan policy, including implementing interventions for residents with falls and/or requiring oxygen administration. 4. MDS coordinator or designee will conduct audits of the care plans 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure that any guest with falls and/or have physician orders for oxygen have care plans initiated. Monitoring will include tracking and trending of issues found during the audits. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

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F 657	Continued From page 70 Status Resident # 53 was coded a 2 (two), moderately impaired of cognition for daily decision making. Resident # 53 was coded as requiring extensive assistance of one staff member for activities of daily living and totally dependent of one staff member for eating. Under section J1900 "Number of Falls Since Admission/Entry or Reentry or Prior Assessment, whichever is more recent" coded Resident # 53 as having two or more falls with no injury. The facility's "Progress Notes" dated "2/15/2019" for Resident # 53 documented, "Guest found on floor of guest room, no injury observed, guest asked what happened but speech garbled and nurse unable to make out what guest was saying, guest vs (vital signs) stable and guest RP (responsible party) and NP (nurse practitioner) notified of fall, neuro (neurological check) started and staff encouraged to check in on guest frequently to assist with needs and concerns, call light placed in reach and staff will continue to monitor." The facility's "Incident Report" dated 02/15/19 for Resident # 53 documented, Under "Post Incident Analysis" "Additional explanation as apparent: Guest to be toileted after peg tube feeding." Following this statement it documented, "The above intervention has been incorporated into the guest's care plan and into the Nursing Care Instruction card" and was signed by ASM (administrative staff member) # 2, the director of nursing with a date of "2/18/19." The comprehensive care plan dated "2/8/19" for Resident # 53 was reviewed. Under "Need" it documented, "(Resident # 53) actual falls and is at risk for falls related injury and future falls R/T	F 657		

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 71 (related to): Confusion, Deconditioning, Gait/balance problems unsteady, non-ambulatory, Incontinence bowel, Poor communication/comprehension, impulsiveness, psychotropic medication use, hemiplegia, restlessness/impulsive, observation of becoming increase restless in dark. Date initiated 02/13/2019. Created on 02/13/2019." Further review of the comprehensive care plan failed to evidence updates or reviews following Resident # 53's fall on 02/15/19. On 03/14/19 at 10:13 a.m., an interview was conducted with RN (registered nurse) # 3, MDS coordinator. After reviewing the comprehensive care plan for Resident # 53 dated 02/13/19 regarding the fall on 2/15/19, RN # 3 stated, "It (comprehensive care plan) should have been updated with intervention of being toileted after peg tube feeding. It's not on the care plan." When asked to describe the procedure for updating a resident's comprehensive care plan, RN # 3 stated, "When a resident falls the nurse is to implement an immediate intervention and it is communicated with management staff then IDT (interdisciplinary team) will meet to discuss falls and revise/update the care plan." When asked what policy they follow for updating the care plan, RN # 3 sated, "We follow the RAI (resident assessment instrument) manual." The RAI (Resident Assessment Instrument) 3.0 User's Manual Version 1.16 dated October 2018 documented, "4.7 The RAI and Care Planning As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 72	F 657		

resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care."

On 02/15/19 at approximately 5:00 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked if the recommendations or the "Additional explanations" documented on an incident report were not documented on the comprehensive care plan, could you say that it was reviewed, revised or updated ASM # 2 stated, "No."

On 03/14/19 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, regional director of operations, and ASM # 4, regional clinical coordinator were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website:
https://medlineplus.gov/ency/article/000726.htm .

(2) A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 73 https://www.nlm.nih.gov/medlineplus/aphasia.html (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 2. The facility staff failed to review and revise Resident #55's care plan to include oxygen administration. Resident #55 was admitted to the facility on 06/10/2015. Diagnoses for Resident #55 included but were not limited to Depression, Heart Failure, and Anxiety. Resident #55's Minimum Data Set (quarterly assessment) with an Assessment Reference Date of 02/08/2019 coded Resident #55 with moderate cognitive impairment. In addition, the Minimum Data set (MDS) coded Resident #55 as requiring existence assistance of one staff member with activities of daily living and limited assistance of one staff member with eating. On 03/12/2019, Resident #55's clinical record was reviewed. The review showed a physician order dated 02/06/2019 that documented, "Oxygen at 2 liters per minute every shift for shortness of breath. Resident #55's care plan dated 9/22/17, had not been reviewed and revised to include administering oxygen for shortness of breath." On 03/12/2019 at approximately 11:15 a.m., Resident #55 was observed in bed wearing a nasal cannula connected to an oxygen concentrator. The concentrator was turned on and the ball on the flow meter was observed between two and two and a half liters.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 74 An interview was conducted on 03/13/2019 at approximately 1:35 p.m. with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked who is responsible for implementing and updating the care plans. ASM #2 stated, "MDS Coordinator and MDS Nurses are responsible for implementing and updating the resident care plans." ASM #2 stated that nurses and unit managers are supposed to update the care plans as well but main MDS staff does the updates. ASM #2 was made aware that Resident #55's care plan had not been reviewed and revised to include oxygen administration for shortness of breath. An interview was conducted on 03/13/2019 at approximately 1:37 p.m. with RN (registered nurse) #3 (MDS coordinator). RN #3 was asked who is responsible for implementing and updating the care plan. RN #3 stated, "MDS Coordinator and MDS Nurses implement the care plans and the interdisciplinary team updates them." RN #3 was made aware that Resident #55's care plan had not been reviewed and revised to include oxygen administration for shortness of breath. RN #3 immediately corrected the care plan after being made aware of the omission. On 03/13/2019 at approximately 5:30 p.m., ASM (administrative staff member) #1 (the administrator), ASM #3 (the regional director of operations), (ASM) #2 (the director of nursing) were made aware of findings. No further information was presented prior to exit.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 75 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for two of 53 residents in the survey sample, Residents #315 and #265. 1. The facility staff failed to clarify Resident #315's physician order regarding instruction for the removal of a lidocaine patch. 2. The facility staff failed to ensure that the physicians order for Resident # 265's prednisone (1) was transcribed to the MAR (medication administration record) accurately, resulting in Resident #265 not receiving the prescribed medication from June 12, 2018 through June 18, 2018. The findings include: 1. Resident #315 was admitted to the facility on 7/27/18. Resident #315's diagnoses included but were not limited to multiple rib fractures, dislocation of left shoulder and diabetes. Resident #315's 14 day Medicare MDS (minimum data set) assessment with an ARD (assessment reference date) of 8/8/18, coded the resident's cognition as moderately impaired. Section J coded Resident #315 as reporting occasional pain during the last five days. Review of Resident #315's clinical record revealed a physician's order	F 658	1. Residents #315 and #265 no longer reside in the facility. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All licensed nursing staff will be educated on transcribing and clarifying orders. 4. DON or designee will monitor physician orders 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure lidocaine patch orders include directions for removal and prednisone orders are transcribed to the MAR accurately. Monitoring will include tracking and trending of issues found during the audits. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 76	F 658		

with a start date of 8/2/18 that documented, "Lidocaine Patch 5%. Apply to Left Shoulder, Left Ribs topically one time a day for Pain." Resident #315's August 2018 MAR (medication administration record) documented the same order.

"Lidocaine patches are used to relieve the pain of post-herpetic neuralgia (PHN; the burning, stabbing pains, or aches that may last for months or years after a shingles infection). Lidocaine is in a class of medications called local anesthetics. It works by stopping nerves from sending pain signals.
Lidocaine comes as a patch to apply to the skin. It is applied only once a day as needed for pain. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Use lidocaine patches exactly as directed.
Your doctor will tell you how many lidocaine patches you may use at one time and the length of time you may wear the patches. Never apply more than three patches at one time, and never wear patches for more than 12 hours per day. Using too many patches or leaving patches on for too long may cause serious side effects." (1)

On 3/14/19 at 9:31 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to explain the instructions for the use of a lidocaine patch. LPN #4 stated, "They are usually, usually the order is to put on in the morning and remove in 12 hours. I haven't seen very many that have other instructions. We usually put on at 9 (9:00 a.m.) and take off at 9 (9:00 p.m.)." LPN #4 was asked what should be done if a physician's order does not contain instructions to remove the patch. LPN #4 stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 77	F 658		

"You need to just clarify cause I don't think I have ever seen one put on and just leave." When asked how nurses should clarify the order, LPN #4 stated nurses should contact the nurse practitioner or the physician. LPN #4 was shown Resident #315's lidocaine patch order and LPN #4 confirmed the order should have been clarified to include instructions for the removal of the patch.

Resident #315's care plan dated 7/27/18 failed to document information regarding the clarification of a physician's order for a lidocaine patch.

On 3/14/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional director of operations) and ASM #4 (the regional clinical coordinator) were made aware of the above concern. ASM #4 stated that they followed their facility standards, which were stated to be Lippincott.

On 3/14/19 at 5:32 p.m., OSM (other staff member) #13 (the medical records director) stated the facility did not have a policy or standard of practice regarding physician order clarification.

According to "Lippincott Manual of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 78	F 658		

attending physician, discuss your concerns with him, obtain appropriate ...orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

No further information was presented prior to exit.

(1) This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a603026.html

2. The facility staff failed to ensure that the physicians order for Resident # 265's prednisone (1) was transcribed to the MAR (medication administration record) accurately, resulting in Resident #265 not receiving the prescribed medication from June 12, 2018 through June 18, 2018.

Resident # 265 was admitted to the facility on 05/03/18 with diagnoses that included but were not limited to: heart failure (2), dementia (3), benign prostatic hyperplasia (4) and pituitary tumor (5).

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 05/10/2018, coded the Resident # 265 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 3 (three) being severely impaired of cognition for daily decision-making. Resident # 265 was coded as requiring limited assistance of one staff member for activities of daily living.

The physician's telephone orders dated 06/11/18, for Resident # 265 documented, "Prednisone 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 79	F 658		

mg (five milligram) now" and "Prednisone 5mg PO (by mouth) q (every) day."

The eMAR (electronic medication administration record) dated "June 2018" for Resident # 265 documented, "Prednisone Tablet 5 MG. Give 1 (one) tablet by mouth one time only for pain for 1 (one) Day. Start Date: 6/11/2018." Review of the eMAR revealed a check mark on June 11, 2018 at 1849 (6:49 p.m.). Further review of the eMAR dated "June 2018" for Resident # 265 failed to evidence Resident # 265 receiving another dose of prednisone until June 18, 2018, a lapse of six days. On this date, the eMAR documented, "Prednisone Tablet 5 MG. Give 1 (one) tablet by mouth one time a day for inflammation. Start Date: 6/18/2018."

Review of the facility's "(Name of Medication Back up System) Inventory" sheet revealed the presence of prednisone. The inventory sheet documented, "Prednisone 10 MG Tablet."

On 03/14/19 at 4:00 p.m., an interview was conducted with RN (registered nurse) # 6, unit manager. When asked about the check marks and 'X"s on the Resident #265's eMAR, RN # 6 stated that the check marks indicated the medication was given and the 'X"s indicated it was not done. RN # 6 was asked to review Resident # 265's eMAR dated "June 2018" and the physician's telephone orders dated 06/11/18. When asked if the physician's order was followed for the administration of prednisone, RN # 6 stated, "The order was entered into the system for the prednisone to be given now but not for the administration every day." When asked if Resident # 265 had received the prednisone from June 12, 2018 through June 18, 2018, RN # 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 80	F 658		

reviewed the eMAR dated "June 2018" and stated no. When asked to describe the process that staff should follow to ensure a resident is receiving a physician ordered medication, RN # 6 stated, "When they (nursing) receive the order from the doctor they enter it in the system and follow it." When asked who signed the telephone order for the prednisone, RN # 6 stated it was (RN # 7).

On 03/14/19 at 4:11 p.m., an interview was conducted with RN (registered nurse) # 7. After reviewing the eMAR and telephone order for Resident # 265's prednisone, RN # 7 stated she signed the order. When asked why Resident # 265 did not receive prednisone from June 12, 1019 through June 18, 2019 and why the physician's order was not followed, RN # 7 agreed Resident # 265 did not receive the medication and stated, "I don't know what happened."

On the morning of 03/14/2019, during a brief interview conducted with by another surveyor, ASM #4 stated that they (the facility) followed their facility standards, which were stated to be Lippincott.

On 03/14/19 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, regional director of operations, and ASM # 4, regional clinical coordinator were made aware of the findings.

According to "Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 81 by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. Be sure to look for order duplications that could cause your patient to receive a medication in error...." Page 181 reads, "Nurses carry a great deal of responsibility for making sure that patients get the right drugs at the right time, in the right dose and by the right routes ...this includes accurate documentation and explanation ... " No further information was provided prior to exit. Complaint deficiency References: (1) Used alone or with other medications to treat the symptoms of low corticosteroid levels (lack of certain substances that are usually produced by the body and are needed for normal body functioning). Prednisone is also used to treat other conditions in patients with normal corticosteroid levels. These conditions include certain types of arthritis; severe allergic reactions; multiple sclerosis (a disease in which the nerves do not function properly); lupus (a disease in which the body attacks many of its own organs); and certain conditions that affect the lungs, skin, eyes, kidneys blood, thyroid, stomach, and intestines. Prednisone is also sometimes used to treat the symptoms of certain types of cancer. Prednisone is in a class of medications called corticosteroids. It works to treat patients with low levels of corticosteroids by replacing steroids that are normally produced naturally by the body. It works to treat other conditions by reducing swelling and redness and by changing the way the immune system works. This information was obtained from the website:	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 82 https://medlineplus.gov/druginfo/meds/a601102.html. (2) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm. (3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (4) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (5) The pituitary gland is involved in the production of several essential hormones. Tumors arising from the pituitary gland itself are called adenomas or carcinomas. Pituitary adenomas are benign, slow-growing masses that represent about 10% of primary brain tumors. Pituitary carcinoma is the rare malignant form of pituitary adenoma. It is diagnosed only when there is proven spread (metastases) inside or outside the nervous system. This information was obtained from the website: https://www.abta.org/tumor_types/pituitary-tumors/?gclid=EAIaIQobChMI3tb7sKCM4QIVFMDICh12OgmFEAAYAyAAEgLODfD_BwE.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 83 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to provide the necessary services to maintain good grooming, and personal hygiene for one of 53 residents in the survey sample, Resident #315. The facility staff failed to provide a shower and/or bath from 7/30/18 through 8/13/18, to Resident #315, who was coded as requiring extensive assistance of one with Activities of daily living. The findings include: Resident #315 was admitted to the facility on 7/27/18. Resident #315's diagnoses included but were not limited to multiple rib fractures, dislocation of left shoulder and diabetes. Resident #315's 14 day Medicare MDS (minimum data set) assessment with an ARD (assessment reference date) of 8/8/18, coded the resident's cognition as moderately impaired. Section G coded Resident #315 as requiring extensive assistance of two or more staff with bed mobility/transfers and as requiring extensive assistance of one staff with locomotion, dressing, eating, toilet use and personal hygiene. Section G further coded bathing as activity itself did not occur or family and/or non-facility staff provided care 100% of the time. Review of Resident #315's July 2018 and August	F 677	1. Resident # 315 no longer resides in the facility. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All nursing staff will be educated on the shower/bathing policy. 4. DON or designee will monitor shower documentation 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure guests requiring extensive assistance are receiving showers and/or baths. Monitoring will include tracking and trending of issues found during the audits. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 677	Continued From page 84 2018 ADL (activity of daily living), documentation revealed the resident did not receive a shower and/or bath between 7/30/18 and 8/13/18. Review of nurses' notes from 7/30/18 through 8/13/18 failed to reveal documentation regarding showers/baths. Resident #315's care plan dated 7/27/18 documented, "Requires assistance with ADL's r/t (related to) multiple fractures, shoulder dislocation, generalized weakness..." The care plan failed to document specific information regarding showers/baths. On 3/13/19 at 3:23 p.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated showers are given to residents, twice a week by the shower aide. CNA #3 stated the CNA assigned to the resident must provide the shower if the shower aide cannot do so. When asked if showers are documented, CNA #3 stated showers are documented in the computer system. When asked what is meant if a shower is not documented, CNA #3 stated, "It wasn't given." On 3/14/19 at 8:15 a.m., an interview was conducted with CNA #1 (one of the facility shower aides). CNA #1 stated residents are given showers twice a week. When asked if she was able to complete all of the scheduled showers, CNA #1 stated she tries her best and the other CNAs help her if needed. CNA #1 was asked if she documents the showers, she provides. CNA #1 stated she does so in the computer system. When asked what is meant if showers are not documented in the computer system, CNA #1 stated, "It shouldn't be that way because even if they don't get a shower they get a bed bath so it still has to be documented."	F 677		

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 677	Continued From page 85 On 3/14/19 at 9:31 a.m., LPN (licensed practical nurse) #4 (unit manager) was made aware of the above concern and asked to provide evidence that Resident #315 received a shower or bath between 7/30/18 and 8/13/18. On 3/14/19 at 1:27 p.m., another interview was conducted with LPN #4. LPN #4 stated Resident #315's scheduled shower days were Mondays and Thursdays. LPN #4 stated Resident #315 should have received a shower on 8/2/18. LPN #4 stated she spoke to the shower aide who was responsible for giving showers that day and the shower aide could not remember giving Resident #315 a shower on that day. LPN #4 stated Resident #315 should have received a shower on 8/6/18. LPN #4 stated she was not able to reach the shower aide responsible for giving showers on that day. LPN #4 stated Resident #315 should have received a shower on 8/9/18. LPN #4 stated she spoke to the shower aide who was responsible for giving showers on that day and the shower aide could not remember giving Resident #315 a shower on that day. On 3/14/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional director of operations) and ASM #4 (the regional clinical coordinator) were made aware of the above concern. The facility policy titled, "SHOWER/BATH" documented, "Unless otherwise directed by the charge nurse, all guests will receive either a shower bath or whirlpool bath twice weekly. Additional bathing will be accommodated upon guest and/or family request."	F 677		

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 677	Continued From page 86 No further information was presented prior to exit.	F 677		
	COMPLAINT DEFICIENCY			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure two of 53 sampled residents, (Resident #92 and Resident #265), received treatment and care in accordance with professional standards of practice and the comprehensive care plan. 1. The facility staff failed to have blood work drawn according to the physician orders for Resident #92. 2. The facility staff failed to administer Resident # 265's was prednisone (1) as prescribed by the physician. Resident #265's prednisone was not transcribed to the MAR (medication administration record) accurately, resulting in Resident #265 not receiving the prescribed medication from June 12, 2018 through June 18, 2018.	F 684	1. Residents #92 and #265 no longer reside in facility. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All licensed nursing staff will be educated on following prescribed physician orders. 4. DON or designee will monitor physician orders 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure physician prescribed bloodwork is drawn and prednisone is administered as prescribed. Monitoring will include tracking and trending of issues found during the audits. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and	4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 684	Continued From page 87 The findings include: 1. Resident #92 was admitted to the facility on 1/24/19 with diagnoses that included but were not limited to: brain cancer, muscle weakness, diabetes, depression, and high blood pressure. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 2/20/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable or making daily cognitive decisions. The physician order dated 1/25/19 documented, "CBC* and CMP** weekly starting on 1/28/19." *A complete blood count or CBC is a blood test that measures many different parts and features of your blood, including: Red blood cells, which carry oxygen from your lungs to the rest of your body. White blood cells, which fight infection. There are five major types of white blood cells. A CBC test measures the total number of white cells in your blood. A test called a CBC with differential also measures the number of each type of these white blood cells. Platelets, which help your blood to clot and stop bleeding. Hemoglobin, a protein in red blood cells that carries oxygen from your lungs and to the rest of your body. Hematocrit, a measurement of how much of your blood is made up of red blood." (1). ** A Comprehensive Metabolic Panel (CMP) is used as a broad screening tool to evaluate organ function and check for conditions such as diabetes, liver disease, and kidney disease. The	F 684	will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

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F 684	Continued From page 88	F 684		

CMP may also be ordered to monitor known conditions, such as hypertension, and to monitor people taking specific medications for any kidney- or liver-related side effects. If a doctor is interested in following two or more individual CMP components, she may order the entire CMP because it offers more information. (2).

Review of the clinical record failed to evidence documentation of the above ordered laboratory tests for 2/18/19.

Review of the "Diagnostic/Laboratory Administration Record" failed to document the orders for the weekly physician ordered CBC and CMP.

Review of the nurse's notes failed to evidence documentation related to the above ordered laboratory tests.

The comprehensive care plan dated, 1/28/19 and revised on 2/7/19, documented in part, "Focus: (Resident #92) is at risk for complications of chemotherapy/radiation r/t (related to) cancer - right temporal brain tumor." The "Interventions" documented in part, "Obtains labs (laboratory tests) and diagnostics as ordered and report abnormal findings to the physician."

An interview was conducted with RN (registered nurse) #1, the assistant director of nursing, on 3/14/19 at 2:31 p.m. When asked about the process staff follows for obtaining a physician ordered laboratory tests, RN #1 stated the nurse puts the order in (name of computer program). It's to be scheduled for the night shift. The nurse confirms the order, does the lab (laboratory) requisition and then the lab company comes

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F 684	Continued From page 89 between 3:00 a.m. and 4:00 a.m. to draw the blood." When asked how the facility tracks that the ordered lab tests have been done, RN #1 stated the facility has the lab tracking form and the results get faxed to the facility and scanned into (name of computer program). The orders above were reviewed with RN #1. RN #1 was informed that the laboratory test results for 2/18/19 physician ordered lab test could not be located in the clinical record. RN #1 stated she would go look into it. On 3/14/19 at 4:12 p.m., RN #1 stated she could not find the lab result or the lab requisition slip for the laboratory test ordered for 2/18/19. An interview was conducted with administrative staff member (ASM) #5, the nurse practitioner, on 3/14/19 at 5:10 p.m. When asked if she had ordered the CBC and CMP, ASM #5 reviewed the clinical record and stated the order had come from someone outside of the facility. ASM #5 reviewed the scanned documents in the clinical record and stated, "The order came on his discharge instructions from the hospital. The labs were ordered to follow up on his platelets and his liver function." The CBC dated, 2/11/19, documented his platelet count as being 174, with the normal range being 130 - 400. The CBC dated, 2/25/19, documented his platelet count as being 105, being below the normal range of 130 - 400. The CMP dated, 2/11/19, documented the following "Liver Function Tests***" laboratory results: SGPT - 60 - normal range is 7 - 52 U/L (units per liter)	F 684		

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F 684	Continued From page 90 SGOT - 20 - normal 13 - 39 U/L Alkaline phosphatase - 72 normal 34 - 104 U/L Total Bilirubin - 0.5 - normal 0.20 - 1.20 mg/dL (Milligram/grams per deciliter) Total Protein - 4.5 - normal 6.0 - 8.3 g/dL The CMP dated, 2/25/19, documented the following laboratory results: SGPT [serum glutamic-pyruvic transaminase part of a liver panel] - 67, higher than previous, above normal range SGOT [serum glutamic-oxaloacetic transaminase also part of liver panel]- 25 - higher than previous, but still in normal range Alkaline phosphatase - 74 - higher but still in normal range Total Bilirubin - 0.8 - higher but still in normal range Total Protein - 4.6 - increased but still not in normal range ***Liver function tests measure certain proteins, enzymes, and substances, including: o Albumin, a protein that the liver makes o Total protein (TP) o Enzymes that are found in the liver, including alanine transaminase (ALT), aspartate transaminase (AST), alkaline phosphatase (ALP), and gamma-glutamyl transpeptidase (GGT) o Bilirubin, a yellow substance that is part of bile. It is formed when your red blood cells break down. Too much bilirubin in the blood can cause jaundice. There is also a urine test for bilirubin. (3) ASM #1, the administrator, and ASM #3, the regional director of operations, were made aware of the above findings on 3/14/19 at 4:33 p.m.	F 684		

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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F 684	Continued From page 91 The facility policy, "Medication Administration" documented in part, "Policy: All medications and treatments shall be initiated, administered and/or discontinued in accordance with written physician orders." In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/lab-tests/complete-blood-count-cbc/ (2) This information was obtained from the following website: 2. http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&query=CMP&x=9&y=21 (3) This information was obtained from the following website: https://medlineplus.gov/liverfunctiontests.html 2. The facility staff failed to administer Resident # 265's was prednisone (1) as prescribed by the physician. Resident #265's prednisone was not transcribed to the MAR (medication administration record) accurately, resulting in Resident #265 not receiving the prescribed medication from June 12, 2018 through June 18, 2018. Resident # 265 was admitted to the facility on	F 684		

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

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F 684	Continued From page 92	F 684		

05/03/18 with diagnoses that included but were not limited to: heart failure (2), dementia (3), benign prostatic hyperplasia (4) and pituitary tumor (5).

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 05/10/2018, coded the Resident # 265 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 3 (three) being severely impaired of cognition for daily decision-making. Resident # 265 was coded as requiring limited assistance of one staff member for activities of daily living.

The physician's telephone orders dated 06/11/18, for Resident # 265 documented, "Prednisone 5 mg (five milligram) now" and "Prednisone 5mg PO (by mouth) q (every) day."

The eMAR (electronic medication administration record) dated "June 2018" for Resident # 265 documented, "Prednisone Tablet 5 MG. Give 1 (one) tablet by mouth one time only for pain for 1 (one) Day. Start Date: 6/11/2018." Review of the eMAR revealed a check mark on June 11, 2018 at 1849 (6:49 p.m.). Further review of the eMAR dated "June 2018" for Resident # 265 failed to evidence Resident # 265 receiving another dose of prednisone until June 18, 2018, a lapse of six days. The eMAR documented, "Prednisone Tablet 5 MG. Give 1 (one) tablet by mouth one time a day for inflammation. Start Date: 6/18/2018."

Review of the facility's "(Name of Medication Back up System) Inventory" sheet revealed the presence of prednisone. The inventory sheet

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 684	Continued From page 93 documented, "Prednisone 10 MG Tablet." On 03/14/19 at 4:00 p.m., an interview was conducted with RN (registered nurse) # 6, unit manager. When asked about the check marks and 'X''s on the Resident #265's eMAR, RN # 6 stated that the check marks indicated the medication was given and the 'X''s indicated it was not done. RN # 6 was asked to review Resident # 265's eMAR dated "June 2018" and the physician's telephone orders dated 06/11/18. When asked if the physician's order was followed for the administration of prednisone, RN # 6 stated, "The order was entered into the system for the prednisone to be given now but not for the administration every day." When asked if Resident # 265 had received the prednisone from June 12, 2018 through June 18, 2018, RN # 7 reviewed the eMAR dated "June 2018" and stated no. When asked to describe the process that staff should follow to ensure a resident is receiving a physician ordered medication, RN # 6 stated, "When they (nursing) receive the order from the doctor they enter it in the system and follow it." When asked who signed the telephone order for the prednisone, RN # 6 stated it was (RN # 7). On 03/14/19 at 4:11 p.m., an interview was conducted with RN (registered nurse) # 7. After reviewing the eMAR and telephone order for Resident # 265's prednisone RN # 7 stated she signed the order. When asked why Resident # 265 did not receive prednisone from June 12, 1019 through June 18, 2019 and why the physician's order was not followed, RN # 7 agreed Resident # 265 did not receive the medication and stated, "I don't know what happened."	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 684	Continued From page 94 On the morning of 03/14/2019, during a brief interview conducted by another surveyor, ASM #4 stated that they (the facility) followed their facility standards, which were stated to be Lippincott. On 03/14/19 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, regional director of operations, and ASM # 4, regional clinical coordinator were made aware of the findings. According to "Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007, Page 181 reads, "Nurses carry a great deal of responsibility for making sure that patients get the right drugs at the right time, in the right dose and by the right routes ...this includes accurate documentation and explanation ... " No further information was provided prior to exit. Complaint deficiency References: (1) Used alone or with other medications to treat the symptoms of low corticosteroid levels (lack of certain substances that are usually produced by the body and are needed for normal body functioning). Prednisone is also used to treat other conditions in patients with normal corticosteroid levels. These conditions include certain types of arthritis; severe allergic reactions; multiple sclerosis (a disease in which the nerves do not function properly); lupus (a disease in which the body attacks many of its own organs); and certain conditions that affect the lungs, skin, eyes, kidneys blood, thyroid, stomach, and	F 684		

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	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 684	Continued From page 95	F 684		

intestines. Prednisone is also sometimes used to treat the symptoms of certain types of cancer. Prednisone is in a class of medications called corticosteroids. It works to treat patients with low levels of corticosteroids by replacing steroids that are normally produced naturally by the body. It works to treat other conditions by reducing swelling and redness and by changing the way the immune system works. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601102.html.

(2) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm.

(3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(4) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

(5) The pituitary gland is involved in the production of several essential hormones. Tumors arising from the pituitary gland itself are called adenomas or carcinomas. Pituitary adenomas are benign, slow-growing masses that represent about 10% of primary brain tumors. Pituitary carcinoma is the rare malignant form of pituitary adenoma. It is diagnosed only when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 96 there is proven spread (metastases) inside or outside the nervous system. This information was obtained from the website: https://www.abta.org/tumor_types/pituitary-tumors/?gclid=EAIaIQobChMI3tb7sKCM4QIVFMDICh12OgmFEAAYAyAAEgLODfD_BwE.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690		4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 690	Continued From page 97 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, facility document review and clinical record review, it was determined the facility staff failed to provide treatment and services to maintain or restore bladder and bowel function for one of 53 residents in the survey sample, Resident #92. The facility staff failed to implement a toileting plan to maintain or restore Resident #92's bladder and bowel function. The findings include: Resident #92 was admitted to the facility on 1/24/19 with diagnoses that included but were not limited to: brain cancer, muscle weakness, diabetes, depression, and high blood pressure. The "Nursing Comprehensive Evaluation" dated, 1/24/19, documented in part, under "Section F. Genitourinary" that the resident was continent of both bowel and bladder. The MDS (minimum data set) assessment, an admission/Medicare Five day assessment, with an assessment reference date of 1/31/19, coded the resident in Section H - Bladder and Bowel as being frequently incontinent of bowel and bladder (2 or more episodes of urinary or bowel incontinence, but at least one episode of continent voiding or bowel movement). The resident was not coded as being on a toileting	F 690	1. Resident #92 no longer resides in the facility. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All licensed nursing staff will be educated on identifying and implementing a toileting program for bowel/bladder incontinence. 4. MDS coordinator or designee will audit Section H on the 5 day MDS assessment to compare with the genitourinary section on the nursing comprehensive evaluation. Identified variances will be evaluated for implementation of a toileting program. Auditing will occur 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure bladder and bowel function is maintained or restored. Monitoring will include tracking and trending of issues found during the audits. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 98 program for bowel or bladder. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 2/20/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable or making daily in cognitive decisions. In Section H - Bladder and Bowel as being frequently incontinent of bowel and bladder (2 or more episodes of urinary or bowel incontinence, but at least one episode of continent voiding or bowel movement). The resident was not coded as being on a toileting program for bowel or bladder. Upon entrance, a list of resident's with pressure ulcers was requested. On 3/12/19 at 11:04 a.m., administrative staff member (ASM) #2, the director of nursing, stated that Resident #92 did not have a pressure ulcer but moisture associated skin damage. The comprehensive care plan dated, 1/28/19, documented in part, "(Resident #92) is incontinent of bowel and bladder." The "Interventions" documented in part, "Check q(every) 2 hr (hours) and prn (as needed) for incontinence. Wash, rinse and dry perineum, change clothing after incontinence care as needed. Provide incontinent care with moisture barrier as needed after incontinent episodes." An interview was conducted with Resident #92 and his wife on 3/12/19 at 11:15 a.m. When asked if he was continent of bowel and bladder, the resident's wife stated that if the urinal is properly placed for him, he could use it. She further stated that she and his sons place it for	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

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F 690	Continued From page 99	F 690		

him when he asks. The resident was asked if he could tell when he needs to urinate and have a bowel movement, Resident #92 stated, "Most of the time." They informed the surveyor that he wears a brief at all times and no one has offered the bedpan or urinal since they've been here.

On 3/13/19 at 4:03 p.m., ASM #2, the director of nursing, informed this surveyor that she observed Resident #92's buttock yesterday. ASM #2 stated she felt she needed to look at it herself. She stated that the resident had an order for Medihoney as treatment that started on 3/11/19. She stated, "I felt it was a stage 2 pressure injury on his right buttock, it was beefy red and the top layer of skin was gone. The sacral/coccyx was measured as 0.5 cm (centimeters) length by 0.5 cm in width. It was like a hole with a yellow base. With that I called the nurse practitioner as to when she last saw the areas and she stated she had seen them on 3/8/19 and again on 3/11/19 and they were not as described to her." ASM #2 stated that they felt it was no longer moisture associated skin damage but a pressure ulcer.

An interview was conducted with RN (registered nurse) #6, the unit manager, on 3/14/19 at 10:17 a.m. RN #6 was asked to review the "Nursing Comprehensive Evaluation" dated, 1/24/19. The MDS assessments above were reviewed also. When asked if the resident was on a toileting program, RN #6 stated, "We can look at it." When asked why the resident should feel like he has to use a brief and sit in a wet/soiled brief, RN #6 stated, "He shouldn't. I'll go look at it."

An interview was conducted with RN #1, the assistant director of nursing on 3/14/19 at 2:31 p.m. The "Nursing Comprehensive Evaluation"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 100	F 690		

dated, 1/24/19, was reviewed with RN #1. The MDS assessments above were reviewed also. When asked why the resident is wearing briefs, RN #1 stated, "He shouldn't be." When asked if he should be on a toileting program, RN #1 stated, "Yes, even if it's only 50 % of the time, he should be."

An interview was conducted with RN #6 on 3/14/19 at 3:12 p.m. RN #6 stated she went to talk to the resident's wife but the resident was being sent out to the hospital. She spoke with the nurse who completed the "Nursing Comprehensive Evaluation" dated, 1/24/19 and the nurse stated it should not have been documented as continent that was an error. RN #6 stated, "I asked the nurse and aides if the family or resident had asked for a urinal and they told me they have never asked. The CNAs (certified nursing assistants) who care for Resident #92 were interviewed by RN #6 and they informed her that the resident and/or his family has ever voiced the need to use the bathroom. She recalled a conversation with the wife to leave the brief open but even during the care plan conference recently she never voiced anything related to toileting.

The facility policy, "Bowel & Bladder Continence Program" documented in part, "Purpose: Assisting a resident to maintain or restore bowel and bladder continence may promote the following: Dignity, Independence, participation in activities and social functions, confidence, improved skin integrity.....Facility staff will provide information and education to the resident's family and/or legal representative on choices related to their continence care and services related to their continence. Procedure: 1. Review the Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 101 Comprehensive Evaluations to determine if the resident is incontinent of bowel or bladder. 2. Compete the Bowel Evaluation and/or Urinary Incontinence History and Observations when any level of incontinence in bowel and/or bladder is identified on the Nursing Comprehensive Evaluation. 3. Initiated the Elimination Pattern for a minimum of 3 days to collect information on elimination pattern of the resident....6. Behavior modification programming may be initiated of resident who meet the following requirements: a. Bladder or Bowel Retraining Program: i. Able to communicate a need to eliminate, ii. Experience an urge to eliminate, iii. Physical ability to delay elimination until reaching toilet, iv. Willing and able to participate, independently, or with prompts. b. Prompted/Structured Toileting: i. Able to establish patterns and/or cues indicating time and need for toileting, ii Will and able to participated, independently or with prompts. 7. Discuss the findings with the resident, family and/or legal representative and determine interventions to be included in the plan of care. Determine the resident's willingness and ability to participate in interventions. 8. Determine the appropriate plan for a resident unable to participated in a continence program. Reasons for not participating include, but were not limited to: a. Unable to participate due to: i. Indwelling catheter required to treat an irreversible medical condition, ii. comatose, iii. Unable to tolerate placement of bedpan, commode or toilet...v. Inability to identify the urge to urinate or have a bowel movement." ASM #1, the administrator, and ASM #3, the regional director of operations, were made aware of the above concern on 3/14/19 at 4:33 p.m.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 102 No further information was provided prior to exit.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that facility staff failed to provide respiratory care and services consistent with professional standards of practice for four of 53 residents in the survey sample, Residents # 9, # 104, # 55, and # 23. 1. The facility staff failed to store Resident # 9's BI-PAP [bi-level positive air pressure] (1) mask and tubing in a sanitary manner. During multiple observations of Resident 9's BI-PAP mask and tubing, revealed the mask was stored uncovered and not in a bag. 2. The facility staff failed to administer Resident #104's oxygen according to physician's orders. 3. The facility staff failed to administer Resident #55's oxygen according to the physician's order. 4. The facility staff failed to store Resident #23's respiratory equipment in a sanitary manner.	F 695	1. Residents #9 has been care planned for the preference not to have respiratory accessories placed in a protective bag. Resident #104 is receiving oxygen administration according to physician orders. Resident #55 is receiving oxygen administration according to physician orders. Resident #23's respiratory equipment is being stored in a sanitary manner. 2. All residents receiving oxygen therapy or have respiratory equipment have the potential to be affected by this alleged deficient practice. All residents with orders for oxygen and/or CPAP have been audited and are receiving oxygen in accordance with physician orders and/or respiratory equipment is being stored in sanitary manner. 3. All licensed nursing staff will be educated on following physician orders for administering oxygen. All staff will be educated how to store respiratory	4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 103 The findings include: 1. The facility staff failed to store Resident # 9's BI -PAP (continuous positive air pressure) mask and tubing in a sanitary manner. Resident # 9 was admitted to the facility on 10/17/15 and a readmission on 11/02/10 with diagnoses that included but were not limited to: Parkinson's disease (2), multiple sclerosis (3), and sleep apnea (4). Resident # 9's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 07/09/18 coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact for daily decision-making. Resident # 9 was coded as requiring supervision and set up for activities of daily living and independent with eating. Section O "Special Treatments, Procedures and Programs" coded Resident # 9 as using a BI -PAP. On 03/12/19 at 1:55 p.m., an observation of Resident # 9 revealed she was sitting in a chair next to her bed reading. Observation of Resident # 9's BI-PAP mask revealed it was hanging on the bed rail uncovered. The BI -PAP machine was sitting on top of the bedside table with the tubing connected to the machine. The other end of the tubing was uncovered, hanging down in front of the bedside table, and resting on the floor. On 03/13/19 at 10:34 a.m., an observation of Resident # 9 sitting in a chair next to her bed reading. Observation of Resident # 9's BI-PAP mask revealed it was laying on the bed	F 695	equipment in a sanitary manner. 4. DON or designee will audit all guests with oxygen and/or BiPAPs 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure physician orders are being followed and respiratory equipment is being stored in a sanitary manner. Monitoring will include tracking and trending of issues found during the audits. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 104	F 695		

uncovered. The BI -PAP machine was sitting on top of the bedside table with the tubing connected to the machine. The other end of the tubing was uncovered, hanging down in front of the bedside table, and resting on the floor.

On 03/13/19 03:09 p.m., an observation of Resident # 9 revealed she was sitting in a chair next to her bed reading. Observation of Resident # 9's BI-PAP mask revealed it was laying on the bed uncovered. The BI -PAP machine was sitting on top of the bedside table with the tubing connected to the machine. The other end of the tubing was uncovered, hanging down in front of the bedside table, and resting on the floor.

The POS (physician's order sheet) dated 01/24/2019 for Resident # 9 documented, "Bipap 16 cm (centimeters) h20 (hour) (BIPAP) sleeping every night. Start Date: 1/22/2017."

The comprehensive care plan dated 01/10/2019 for Resident # 9 documented, "Need: (Resident # 9) has a potential for difficulty breathing and risk for respiratory complications R/T (related to): Obstructive Sleep Apnea. Date initiated 01/10/2019. Under "Interventions it documented, "Administer medication & (and) treatments per physician orders. Monitor for effectiveness, side effects and adverse reactions, report findings to the physician. BI-PAP. Date initiated: 01/10/2019."

On 03/13/19 at 4:04 p.m., an observation of Resident # 9's room and interview was conducted with LPN (licensed practical nurse) # 7. When asked to describe the procedure for storing a BI-PAP mask and tubing, LPN # 7 stated, "It goes in plastic bag when not in use." When asked why

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 105	F 695		

the mask and tubing are stored in a plastic bag, LPN # 7 stated, "To keep it clean." After observing the BI-PAP mask lying on the bed uncovered and the tubing hanging down in front of the bed side table with the end uncovered and resting on the floor, LPN # 7 stated, "She (Resident # 9) does put it on and take it off." When asked if there was a plastic bag in Resident # 9's room to store the BI_PAP mask and/ or tubing, LPN # 7 stated, "No." When asked if it is the residents or the nurse's responsibility to ensure the mask and tubing are stored correctly, LPN # 7 stated that the BI-PAP mask and tubing would be removed and cleaned.

On 03/14/19 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, regional director of operations, and ASM # 4, regional clinical coordinator were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Stands for Bilevel Positive Airway Pressure, and is very similar in function and design to a CPAP machine (continuous positive airway pressure). Similar to a CPAP machine, A BiPAP machine is a non-invasive form of therapy for patients suffering from sleep apnea. Both machine types deliver pressurized air through a mask to the patient's airways. The air pressure keeps the throat muscles from collapsing and reducing obstructions by acting as a splint. Both CPAP and BiPAP machines allow patients to breathe easily and regularly throughout the night. This information was obtained from the website: https://www.alaskasleep.com/blog/what-is-bipap-t

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 106 herapy-machine-bilevel-positive-airway-pressure. (2) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. (3) A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or "pins and needles" and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html. (4) Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html. 2. The facility staff failed to administer Resident #104's oxygen according to physician's orders. Resident #104 was admitted to the facility on 02/19/19 with diagnoses that included but were not limited to: anemia (1) heart disease (2), hypertension (3), and idiopathic sleep related non-obstructive alveolar hypoventilation (4). Resident #104's most recent MDS (minimum data set), an admission assessment with an ARD (Assessment Reference Date) of 02/26/19, coded Resident #104 as scoring a 15 on the brief	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 107	F 695		

interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 104 was coded as requiring limited assistance of one staff member for activities of daily living, requiring supervision with set up for eating and as being totally dependent of one staff member for bathing.

On 03/12/2019 at approximately 11:46 a.m., an observation of Resident # 104's room revealed she was resting in her bed watching television. Further observation revealed Resident # 104 was receiving oxygen by nasal cannula connected to an oxygen concentrator. An observation of the oxygen concentrator's flow meter revealed the oxygen flow rate was between two and two-and-a-half liters per minute.

On 03/13/19 at approximately 08:05 a.m., an observation of Resident #104's room revealed Resident #104 was resting in her bed watching television. Further observation revealed Resident # 104 was receiving oxygen by nasal cannula connected to an oxygen concentrator. An observation of the oxygen concentrator flow meter revealed the oxygen flow rate was between two and two-and-a-half liters per minute.

The POS (physician's order sheet) dated March 2019 for Resident #104 documented, "Oxygen at 2 l/m (two liter per minute) via (by) nasal cannula every shift for low sats (saturation). Order Date: 2/19/2019."

On 03/13/19 at approximately 4:45 p.m., an interview was conducted with RN #1 (registered nurse) #1. When asked how to read the oxygen flowrate on the oxygen concentrator, RN #1 stated, "You get down to eye level and read the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 108	F 695		

oxygen flow rate from the oxygen concentrator." RN #1 stated, "The ball has to be centered on the line indicated on the oxygen concentrator flow meter." When asked why it is important to set the oxygen flowrate correctly for the resident, RN #1 stated, "So the resident receives the correct level they are supposed to be getting." When asked what happens if a resident receive too much oxygen RN #1 stated, "A resident with COPD (chronic obstructed pulmonary disease) (5) can suffer over inflation of their lungs." When asked what the physician's orders documented for Resident #104, RN #1 looked at the electronic clinical record and stated, "O2 at two liter per minute, every shift for low O2 saturation." When asked how often the oxygen flow rate is checked on the oxygen concentrator for Resident #104, RN #1 stated, "The flow rate on Resident #104's oxygen concentrator is checked every shift." When asked why Resident 104's oxygen flow rate was set between two and two and a half liters a minute instead of the physician 2 liters a minute, RN #1 stated, "I will check the oxygen setting on Resident #104 and make the necessary adjustment."

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On 03/13/19 at approximately 5:40 p.m., ASM (administrator staff member) #1 administrator, ASM #2, director of nursing, and ASM #3, regional director of operation, were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. If you have anemia, your blood does not carry enough oxygen to the rest of your body. The most

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 109	F 695		

common cause of anemia is not having enough iron. This information was obtained from the website: https://medlineplus.gov/anemia.html - Health Topics

2. Conditions that cause heart attacks. Get more information on heart disease causes, types, and symptoms. This information was obtained from the website: https://www.health.com/condition/heart-disease

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

4. Alveolar hypoventilation is a rare disorder in which a person does not take enough breaths per minute. The lungs and airways are normal. This information was obtained from the website: https://medlineplus.gov/ency/article/000078.htm

5. Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html

6. A procedure for measuring the concentration of oxygen in the blood. The test is used in the evaluation of various medical conditions that affect the function of the heart and lungs. This information was obtained from the website: https://www.medicinenet.com/oximetry/article.htm#how_is_oximetry_done

3. The facility staff failed to administer Resident #55's oxygen according to the physician's order.

Resident #55 was admitted to the facility on 06/10/2015. Diagnoses for Resident #55 included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 110	F 695		

but were not limited to Depression, Heart Failure, and Anxiety. Resident #55's Minimum Data Set (quarterly assessment) with an Assessment Reference Date of 02/08/2019 coded Resident #55 with moderate cognitive impairment. In addition, the Minimum Data set (MDS) coded Resident #55 as requiring existence assistance of one staff member with activities of daily living and limited assistance of one staff member with eating.

On 03/12/19 at approximately 11:20 a.m., Resident #55 was observed in bed receiving oxygen by nasal cannula from an oxygen concentrator. Observation of the oxygen concentrator flow meter documented the flow rate between two and two and a half liters per minute. A second surveyor also observed this observation at eye level of the flow meter.

On 03/12/2019, Resident #55's clinical record was reviewed. The review showed a physician order dated 02/06/2019 that documented, "Oxygen at 2 liters per minute every shift for shortness of breath." Resident #55's care plan did not have oxygen as an intervention.

On 03/13/2019 at approximately 1:16 p.m., LPN (licensed practical nurse) #4 (the unit manager) was interviewed. LPN #4 was asked how staff ensure that resident's oxygen is on the correct setting. LPN #4 stated, "You get down at eye level and make sure the ball on the flow meter is in the middle of the line." LPN #4 was asked why it is important to make sure the resident's oxygen is on the correct setting. LPN #4 stated, "It is important because the resident needs it to avoid having respiratory distress." LPN #4 was made aware of the incorrect oxygen setting observed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 111 two surveyors. On 03/13/2019 at approximately 5:30 p.m., ASM (administrative staff member) #1 (the administrator), ASM #3 (the regional director of operations), ASM #2 (the director of nursing) were made aware of the above concern. The facility document titled, Oxygen Concentrators", documented, "Turn concentrator on and adjust liter flow (to that ordered by physician). Listen for startup alarm. The black liter flow ball on the gauge should be positioned in the middle of the number line (2.0, 2.5, 3.0, 3.5) prescribed by the physician. Liter flow should be checked by being eye level with flow meter. Attach oxygen delivery device to concentrator and place on guest. " No further information was presented prior to exit. 4. The facility staff failed to store Resident #23's respiratory equipment in a sanitary manner. Resident #23 was admitted to the facility on 01/11/2019. Her diagnoses included Diabetes Mellitus Type 2 (a condition causing excessive sugar in the blood), Congestive Heart Failure (1), and Hypertension (high blood pressure). Resident #23's most recent Minimum Data Set (MDS) Assessment was an Admission Assessment with an Assessment Reference Date (ARD) of 01/18/2019. The Brief Interview for Mental Status (BIMS) scored Resident #23 at 15, indicating no impairment. Resident #23 was coded as requiring extensive assistance of 1 person for bed mobility, transfers, dressing, toileting, and hygiene, and as requiring supervision and setup assistance for eating.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 112 An initial tour of the facility was conducted on the morning of 03/12/2019. During the tour, an observation was made of Resident #23's room. It was noted that Resident #23 had a Continuous Positive Airway Pressure (CPAP)(2) device at the bedside. The mask of the device, attached via a flexible hose, was observed to be sitting uncovered on the nightstand. During a follow up observation on the afternoon of 03/13/2019, Resident #23's CPAP mask was observed lying on the Resident's bed, covered by a plastic baggie. However, the hose of the CPAP was hanging off the edge of the bed and draped on the floor. Administrative Staff Members (ASM) #1, the facility Administrator, and ASM #2, the Director of Nursing, were informed of these findings at the end of day meeting on 03/13/2019. The facility staff were asked to provide a copy of any facility policy regarding the storage or use of respiratory equipment. On the morning of 03/14/2019, a brief interview was conducted with ASM #4, the Regional Clinical Coordinator. ASM #4 stated that the facility did not have a specific policy regarding storage or use of respiratory equipment, but rather that they followed their facility standards, which were stated to be Lippincott. From "Infection prevention and control core practices: A roadmap for nursing practice", published by Lippincott in Nursing 2019: August 2018 - Volume 48 - Issue 8 - p 22-28: "Essential elements of standard precautions include: ...	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 113 * Environmental cleaning and disinfection... *reprocessing of reusable medical equipment" The article also notes, "Surfaces, furniture, and equipment in patient rooms must be regularly cleaned and disinfected using agents approved by the Environmental Protection Agency for use in healthcare settings." The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 03/14/2019. No further documentation was provided. 1. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. The weakening of the heart's pumping ability causes: Blood and fluid to back up into the lungs, the buildup of fluid in the feet, ankles and legs - called edema, and tiredness and shortness of breath. - https://medlineplus.gov/heartfailure.html 2. Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. - https://medlineplus.gov/ency/article/001916.htm	F 695		
F 727	RN 8 Hrs/7 days/Wk, Full Time DON	F 727		4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727 SS=D	Continued From page 114 CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure eight consecutive hours of RN (registered nurse) coverage. The facility staff failed to ensure eight consecutive hours of RN coverage for four days, 2/16/19, 3/2/19, 3/3/19 and 3/9/19. The findings include: Review of facility staffing coverage for 2/10/19-3/14/19, revealed the facility failed to staff a RN for eight consecutive hours on 2/16/19, 3/2/19, 3/3/19 and 3/9/19. On 3/13/19 at approximately 8:17 a.m., an interview was conducted with OSM (other staff member) #8 (the staffing coordinator). OSM #8 was asked if she was aware that there was not eight consecutive hours of RN coverage on	F 727	1. No residents were affected by this alleged deficient practice. 2. All residents have the potential to be affected by this alleged deficient practice. 3. Facility will evaluate current staffing schedule to determine RN coverage. Changes will be made to ensure RN staffing is maintained at least 8 consecutive hours a day, 7 days a week. Facility will recruit additional RN staff through online forums and community partnerships. 4. DON or designee and staffing coordinator will meet 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure RN staffing coverage meets requirements. Ongoing compliance will be monitored by the facility's QA committee for 3 months. 5. Corrective action will be completed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 115 2/16/19, 3/2/19, 3/3/19 and 3/9/19. OSM #8 stated that she was aware. OSM #8 was asked if she knew why it was important to have eight consecutive hours of RN coverage daily. OSM #8 stated that eight consecutive hours of RN coverage is needed for supervision of licensed practical nurses, certified nurse aides and to assess residents as needed. OSM #8 stated that if an RN isn't on the schedule and she cannot find one, she would notify the director of nursing. OSM #8 was asked if she notified the director of nursing on the days where there was no RN coverage. OSM #8 stated, "Yes." On 3/13/19 at approximately 9:28 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked if she was made aware that there was not eight consecutive hours of RN coverage on 2/16/19, 3/2/19, 3/3/19 and 3/9/19. ASM #2 stated she was aware and that she is working very hard to make sure the facility has daily RN coverage going forward. OSM #8 also stated that they are seeking to hire a weekend supervisor. On 3/13/19 at approximately 10:40 a.m., ASM #1 (the administrator) stated that the facility does not have a policy for staffing and RN staffing. ASM #1 stated they go by what the regulations say. No further information was given prior to exit.	F 727	4/26/2019	
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its	F 770		4/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 116 residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure one of 53 residents in the survey sample, received the treatment and care in accordance with professional standards of practice and the comprehensive care plan for Resident #92. The facility staff failed to obtain physician ordered laboratory tests for Resident #92. The findings include: Resident #92 was admitted to the facility on 1/24/19 with diagnoses that included but were not limited to: brain cancer, muscle weakness, diabetes, depression, and high blood pressure. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 2/20/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable or making daily cognitive decisions. The physician order dated 1/25/19 documented, "CBC* and CMP** weekly starting on 1/28/19." *A complete blood count or CBC is a blood test that measures many different parts and features	F 770	1. Residents #92 no longer resides in facility. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All licensed nursing staff will be educated on following physician ordered laboratory tests. 4. DON or designee will monitor physician ordered lab work 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure ordered lab work is drawn. Monitoring will include tracking and trending of issues found during the audits. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 117	F 770		

of your blood, including: Red blood cells, which carry oxygen from your lungs to the rest of your body.
White blood cells, which fight infection. There are five major types of white blood cells. A CBC test measures the total number of white cells in your blood. A test called a CBC with differential also measures the number of each type of these white blood cells. Platelets, which help your blood to clot and stop bleeding. Hemoglobin, a protein in red blood cells that carries oxygen from your lungs and to the rest of your body. Hematocrit, a measurement of how much of your blood is made up of red blood." (1).

** A Comprehensive Metabolic Panel (CMP) is used as a broad screening tool to evaluate organ function and check for conditions such as diabetes, liver disease, and kidney disease. The CMP may also be ordered to monitor known conditions, such as hypertension, and to monitor people taking specific medications for any kidney- or liver-related side effects. If a doctor is interested in following two or more individual CMP components, she may order the entire CMP because it offers more information. (2).

Review of the clinical record failed to evidence documentation of the above ordered laboratory tests for 2/18/19.

Review of the "Diagnostic/Laboratory Administration Record" failed to document the orders for the weekly physician ordered CBC and CMP.

Review of the nurse's notes failed to evidence documentation related to the above ordered laboratory tests.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 118 The comprehensive care plan dated, 1/28/19 and revised on 2/7/19, documented in part, "Focus: (Resident #92) is at risk for complications of chemotherapy/radiation r/t (related to) cancer - right temporal brain tumor." The "Interventions" documented in part, "Obtains labs (laboratory tests) and diagnostics as ordered and report abnormal findings to the physician." An interview was conducted with RN (registered nurse) #1, the assistant director of nursing, on 3/14/19 at 2:31 p.m. When asked about the process staff follows for obtaining a physician ordered laboratory tests, RN #1 stated the nurse puts the order in (name of computer program). It's to be scheduled for the night shift. The nurse confirms the order, does the lab (laboratory) requisition and then the lab company comes between 3:00 a.m. and 4:00 a.m. to draw the blood." When asked how the facility tracks that the ordered lab tests have been done, RN #1 stated the facility has the lab tracking form and the results get faxed to the facility and scanned into (name of computer program). The orders above were reviewed with RN #1. RN #1 was informed that the laboratory test results for 2/18/19 physician ordered lab test could not be located in the clinical record. RN #1 stated she would go look into it. On 3/14/19 at 4:12 p.m., RN #1 stated she could not find the lab result or the lab requisition slip for the laboratory test ordered for 2/18/19. An interview was conducted with administrative staff member (ASM) #5, the nurse practitioner, on 3/14/19 at 5:10 p.m. When asked if she had ordered the CBC and CMP, ASM #5 reviewed the	F 770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 119 clinical record and stated the order had come from someone outside of the facility. ASM #5 reviewed the scanned documents in the clinical record and stated, "The order came on his discharge instructions from the hospital. The labs were ordered to follow up on his platelets and his liver function." The CBC dated, 2/11/19, documented his platelet count as being 174, with the normal range being 130 - 400. The CBC dated, 2/25/19, documented his platelet count as being 105, being below the normal range of 130 - 400. The CMP dated, 2/11/19, documented the following "Liver Function Tests***" laboratory results: SGPT - 60 - normal range is 7 - 52 U/L (units per liter) SGOT - 20 - normal 13 - 39 U/L Alkaline phosphatase - 72 normal 34 - 104 U/L Total Bilirubin - 0.5 - normal 0.20 - 1.20 mg/dL (Milligram/grams per deciliter) Total Protein - 4.5 - normal 6.0 - 8.3 g/dL The CMP dated, 2/25/19, documented the following laboratory results: SGPT [serum glutamic-pyruvic transaminase part of a liver panel] - 67, higher than previous, above normal range SGOT [serum glutamic-oxaloacetic transaminase also part of liver panel]- 25 - higher than previous, but still in normal range Alkaline phosphatase - 74 - higher but still in normal range Total Bilirubin - 0.8 - higher but still in normal range Total Protein - 4.6 - increased but still not in normal range	F 770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 120 ***Liver function tests measure certain proteins, enzymes, and substances, including: o Albumin, a protein that the liver makes o Total protein (TP) o Enzymes that are found in the liver, including alanine transaminase (ALT), aspartate transaminase (AST), alkaline phosphatase (ALP), and gamma-glutamyl transpeptidase (GGT) o Bilirubin, a yellow substance that is part of bile. It is formed when your red blood cells break down. Too much bilirubin in the blood can cause jaundice. There is also a urine test for bilirubin. (3) ASM #1, the administrator, and ASM #3, the regional director of operations, were made aware of the above findings on 3/14/19 at 4:33 p.m. The facility policy, "Medication Administration" documented in part, "Policy: All medications and treatments shall be initiated, administered and/or discontinued in accordance with written physician orders." In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/lab-tests/complete-blood-	F 770		

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F 770	Continued From page 121 count-cbc/ (2) This information was obtained from the following website: 2. http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&query=CMP&x=9&y=21 (3) This information was obtained from the following website: https://medlineplus.gov/liverfunctiontests.html	F 770		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to prepare and serve food in a sanitary manner in the kitchen.	F 812	1. Dietary aides are wearing hair nets properly, washing their hands prior to food preparation, and wearing gloves while	4/26/19

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F 812	Continued From page 122 A dietary aide failed to secure their hair properly in a hair net, failed to wash their hands before beginning food preparation, and touched the eating surface of food plates with un-gloved hands. The findings include: A tour of the facility kitchen was conducted on 03/12/2019 at 10:45a.m. An observation of the food preparation and tray line was conducted at 11:30a.m., with Other Staff Member (OSM) #14, a cook. At the beginning of the tray line, OSM #7, a Dietary staff member, was observed leaving the manager's office and walking directly to the tray line to begin assembling resident meal trays. OSM #7 was not observed washing their hands after leaving the manager's office, which entailed touching the doorknob, and was not wearing gloves. During the tray assembly process, OSM #14 was observed filling trays with food, then placing them on top of the service line for OSM #7 to place onto trays, then OSM #7 placed those trays into the meal delivery cart. OSM #7 was observed grabbing the plates from the service line with un-gloved hands, and gripped the plates such that their thumb was pressed into the top, food-bearing surface of the plate. Additionally, OSM #7 was observed wearing a hairnet, however OSM #7 had a long, dreadlocks-style haircut, and the ends of the dreadlocks extended down the back of their neck, to approximately- shoulder height, beyond the restraint of the hair net.	F 812	handling food plates. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All dietary staff will be retrained on the hair restraint policy, handwashing policy, and disposable glove policy. 4. Dietary Manager or designee will monitor food preparation and tray line 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure proper donning of hairnets, hand hygiene, and handling of food plates. Monitoring will include tracking and trending of issues found during the audits. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

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F 812	Continued From page 123 OSM #7 was eventually prompted by the interim Dietary Manager to was their hands and don gloves. The hairnet was not adjusted during tray line. On the afternoon of 03/12/2019, a brief interview was conducted with OSM #14. When asked about how plates should be handled, OSM #7 stated gloves should be worn when handling meal trays and care should be taken to make sure the top surface was not touched. When asked about how a hairnet should be worn, OSM #7 stated that the hair should be completely covered. Administrative Staff Member (ASM) #1, the facility Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 03/13/2019. No further documentation was provided.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		4/26/19

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F 880	Continued From page 124 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 125 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement infection control practices for one of 53 residents in the survey sample, and in the kitchen, Residents #164. The facility staff failed to ensure the implementation of contact isolation precautions for Resident #164. The findings include: Resident #164 was admitted to the facility on 3/7/19 with diagnoses that included but were not limited to: amputation of right great toe, MRSA [MRSA stands for methicillin-resistant Staphylococcus aureus. It causes a staph infection [pronounced "staff infection"] that is resistant to several common antibiotics. (1)], high blood pressure, diabetes, heart failure and has a colostomy [a surgical creation of an opening in the abdominal wall to allow material to pass from the bowel through that opening (2)]. There was no completed MDS (minimum data	F 880	1. Contact isolation precautions are being implemented for resident #164. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All licensed nursing staff will be educated on the contact isolation policy. 4. The Infection Control Nurse or designee will conduct audits on guests on contact isolation 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure proper precautions are being implemented. Monitoring will include tracking and trending of issues found during the audits. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 4/26/2019	

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F 880	Continued From page 126	F 880		

set) assessment. The "Nursing Comprehensive Evaluation" dated, 3/7/19, documented the resident was alert and oriented to time, place and person. The resident was documented as needing one to two person assist with ambulation. Resident #164 was documented as having an active infection and currently on antibiotics.

A nurse's note dated, 3/7/19 at 2:40 p.m., documented in part the following: "Admitted to facility following amputation of left great toe, guest is a+o (alert and oriented time three) and has MRSA in wound of toe....guest orientated (sic) to surroundings, introduced to staff and encouraged to call for assistance when needed, call light placed in reach and staff will continue to monitor."

The physician order dated, 3/8/19, documented, "Contact precautions r/t (related to) MRSA, all services to be provided in room."

Observation was made of Resident #164 on 3/12/19 at 10:55 a.m. The isolation cart and signs were posted outside the resident's room. The resident was not in his room at the time of this observation.

At approximately 1:30 p.m., the resident was observed in his room, in his wheelchair, asleep.

An interview was conducted with RN (registered nurse) #2 on 3/12/19 at 3:34 p.m. When asked what needed to be worn when entering Resident #164's room, RN #1 stated, "He's on contact isolation. You must wear gown and gloves. Anyone going in his room has to be gowned and gloved. When RN #1 was informed Resident

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F 880	Continued From page 127	F 880		

#164 was not in his room for much of the day, RN #2 stated, "He's allowed to come out of the room as long as the area (wound on the residents toe) is covered."

On 3/12/19 at 3:41 p.m., Resident #164's room was observed. A family member was observed in the room. The family member was observed lying across the resident's bed. She did not have any isolation gear on. At 3:56 p.m., the family member was observed walking around the room. At 3:59 p.m., the family member was observed again lying across the resident's bed, without isolation protective gear in place.

An interview was conducted with Resident #164 on 3/13/19 at 10:05 a.m. When asked if he was told anything about being in isolation and it's restrictions, Resident #164 stated he had not been told anything about being on isolation. The resident informed this surveyor, that it was his niece visiting yesterday. I asked if his niece was told anything about the isolation precautions, Resident #164 stated, "No, but they talked to her later in the afternoon about it."

An interview was conducted with RN #1, the assistant director of nursing, on 3/13/19 at 3:09 p.m. When asked if staff explain isolation precautions to residents with precautions in place, RN #1 stated, "I would hope so. The nurse practitioner has long conversations with them." When asked if family members of residents on isolation precautions are instructed on what to do regarding the precautions, RN #1 stated, "It should be done but it's not done every time. The family should be educated."

The comprehensive care plan dated, 3/13/19,

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F 880	Continued From page 128	F 880		

documented in part, "Focus: (Resident #164) at risk for s/sx (signs and symptoms) of acute infection r/t (related to) has MRSA - colonization." The "Interventions" documented in part, "Contact Isolation: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag lines and close bag tightly before taking to laundry. Educate guest and family regarding the importance of following contact precautions. Educate guest and family regarding the importance of hand washing. Use antibacterial soap and disposable towels. Instruct visitors to wear disposable gloves and gown when in resident's room and to wash hands before leaving room."

The facility policy, "Transmission - Based Precautions Contact Precautions" documented in part, "Policy: Contact Precautions will be used (in addition to Standard Precautions) for specified guest known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact or indirect contact...Gloves and Hand Washing: 1. Wear gloves when entering the room. 2. Change gloves during the course of provided care, after having contact with infective material that may contain high concentrations of microorganisms (fecal material and wound drainage). 3. Remove gloves before leaving the room and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent. Gowns: 1. Wear a gown (clean, non-sterile is adequate) when entering the room if you anticipate that your clothing will have substantial contact: a. with the guest, b. with environmental surfaces or items in the guest room ...d. with wound drainage not contained by a dressing. 2. Remove the gown before leaving the guest's

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F 880	Continued From page 129 environment and discard in appropriate container. Ensure that clothing does not contact potentially contaminated environmental surfaces after gown removal ...Visitors: 1. Place a sign on the door of the guest's room and instruct visitors to report to the Nurses' Station prior to entering." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were made aware of the above concern on 3/13/19 at 5:28 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=MRSA&_ga=2.154406129.832194397.1552912848-938173006.1468851256. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 133.	F 880		