PRINTED: 01/16/2020 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	.E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495257	B. WING		C
	PROVIDER OR SUPPLIER		S 1	TREET ADDRESS, CITY, STATE, ZIP CODE 1611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	12/11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMEN	TS	F 000		
F 550 SS=D	survey was conducted Four complaints [Note 1	ollow.  120 certified bed facility was the survey. The survey sample in current Residents reviews bugh #5, #8 and #9) and two ew (Residents #6 and #7).  Exercise of Rights  (1)(2)(b)(1)(2)	F 550		1/13/20
	self-determination access to persons	ent Rights.  a right to a dignified existence, , and communication with and a and services inside and , including those specified in			
	with respect and d resident in a mann promotes mainten her quality of life, r	cility must treat each resident lignity and care for each ner and in an environment that ance or enhancement of his or recognizing each resident's acility must protect and sof the resident.			
	access to quality of	facility must provide equal care regardless of diagnosis, on, or payment source. A facility			
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**Electronically Signed** 

12/24/2019

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		E SURVEY PLETED
		495257	B. WING	vd		C 11/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 550	must establish and practices regarding provision of service residents regardles §483.10(b) Exercise The resident has the rights as a resident or resident of the U §483.10(b)(1) The resident can exercinterference, coercifrom the facility.  §483.10(b)(2) The free of interference reprisal from the farights and to be su exercise of his or his and to be su exercise of his or his REQUIREME by:  Based on observatification of the facility of the facility of the facility.  Based on observation of the facility of t	I maintain identical policies and g transfer, discharge, and the g transfer, discharge, and the es under the State plan for all as of payment source.  See of Rights. The right to exercise his or her tof the facility and as a citizen United States.  If acility must ensure that the ise his or her rights without item, discrimination, or reprisal acility in exercising his or her ported by the facility in the interrights as required under this er rights as required under this er rights as required under this as determined that the facility of the dignity by providing timely for one of nine residents in the sidents # 4.  The exact interview and the facility with under the fac	F 5	The Laurels of Willow Cree have this submitted plan of estand as its allegation of cordate of alleged compliance is 2020.  Preparation and/or execution of correction does not constadmission to, nor agreementhe existence of or the scope of any of the cited deficiencic conclusions set forth in the set deficiencies. This plan is prefered to ensure continuity with regulatory requirements.	correction mpliance. Our is January 13,  n of this plan itute it with, either e and severity es, or statement of epared and/or ng compliance	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	SURVEY
		495257	B. WING		12/1	)  1/2019
	PROVIDER OR SUPPLIER	A. BUILDING		12/11/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 550	Resident # 4 as so interview for menta - 15, 15 - being cog decisions. Resider of one staff members Section H "Bladder 4, as always incontrol on 12/10/19 at 11:00 conducted with Resinterview, Resident soiled. When asked or a staff member stated that she told assistant] at 10:45 being left in a soile makes me feel like On 12/10/19 at 12:00 conducted with CN Resident # 4 was of stated yes. When incontinence care, her at 10:30 [a.m.] said she needed to would get to her affer and I didn't was to change her agail don't know if anyowith her to tell her she could roll I coube an issue." When received incontinents stated, "No, I'll chaeating." When ask Resident # 4 in a series in the state of	oring a 15 on the brief al status (BIMS) of a score of 0 initively intact for making daily at # 4 was coded as dependent or for activities of daily living. In and Bowel" coded Resident # inent of bowel and bladder.  Of a.m., an interview was sident # 4. During the at # 4 stated that her brief was ad if the call bell was activated was notified, Resident # 4. In her CNA [certified nursing a.m. When asked how it felt dibrief, Resident # 4 stated, "It in a, nobody."  Of p.m., an interview was at # 1. When asked if an their caseload, CNA # 1 asked about Resident # 4's CNA # 1 stated, "I changed and she called me back in and a be changed again. I told her I ter lunch. I had just changed and she called me back in and a be changed again. I told her I ter lunch. I had just changed and she called me back in and the reality of the situation. If all do it myself and it wouldn't an asked if Resident # 4 had ance care as of now, CNA # 1 ange her after she finishes are dif it was dignified to leave oiled brief since 10:45 a.m.,	F 550	1. Resident #4 still resides in the and has had a toileting schedule implemented. 2. All residents requiring assistant incontinence care have the potential affected by this alleged deficient providing timely incontinence care. 4. DON or designee will conduct a audits on 10 residents requiring incontinence 5 times a week for 1 withen 3 times a week for 2 weeks are once weekly for 2 weeks to ensure incontinence care is provided. Variativillate corrected at the time of observation, education and correct actions will be provided as needed. Ongoing compliance will be monitod through routine audits and will be reto the facility's QA committee for 3 months. 5. Corrective action will be complete.	ce for al to be actice. ed on random week, and then timely ances ive	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED
		495257	B. WING		12	C 2/11/2019
	PROVIDER OR SUPPLIER	CREEK		STREET ADDRESS, CITY, STATE, ZIP 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 550	On 12/10/19 at 12: conducted with RN manager. When a for providing incont "The residents sho hours if they are ab incontinence care of incontinence care of are informed a resi stated, "As soon as When asked why it incontinence care i stated, "To prevent tract infections." W leave Resident # 4 a.m., RN # 1 stated acceptable."  On 12/10/19 at 12:30 conducted with Resident # 4 was p at 1:00 p.m.  On 12/10/19 at 2:30 conducted with Resident # 4 that incontinence care informed a resident # 4 incontinence care informed a resident # 12:50 incontinence care informed	age 3 30 p.m., an interview was [registered nurse] # 1, unit sked to describe the procedure inence care, RN # 1 stated, uld be checked every two de to tell us if they need or not." When asked how soon should be provided when staff dent requires care, RN # 1 syou can, 20 to 30 minutes." was important to provide n a timely manner, RN # 1 skin breakdown and urinary then asked if it was dignified to in a soiled brief since 10:45 I, "It's not dignified or  55 p.m., an interview was sident # 4. When asked if she tinence care Resident # 4  D p.m., CNA # 1 stated that rovided with incontinence care  D p.m., an interview was sident # 4. Resident # 4 stated are was provided at 1:00 p.m.  The care plan for Resident # 4  D p.m., an interview was sident # 100 p.m. The care plan for Resident # 1	F 55	50		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY MPLETED
		495257	B. WING			C /11/2019
	PROVIDER OR SUPPLIER	REEK	11	TREET ADDRESS, CITY, STATE, ZIP CODE 1611 ROBIOUS ROAD IIDLOTHIAN, VA 23113	1 12	11/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	DBE	(X5) COMPLETION DATE
F 550	The facility's "Resid	ent's Rights" documented, "[1]	F 550			
	must treat each res and care for each re environment that prenhancement of his recognizing each refacility must protect resident."  On 12/10/19 at app (administrative staff administrator, ASM # 3, regional clinica regional director of of the findings.	# 2, director of nursing, ASM I coordinator and ASM # 4, operations, were made aware				
F 600 SS=D	Free from Abuse ar CFR(s): 483.12(a)( §483.12 Freedom f Exploitation The resident has the neglect, misapproper and exploitation as includes but is not lead to corporal punishment any physical or cheet reat the resident's §483.12(a) The fact §483.12(a)(1) Not aphysical abuse, con involuntary seclusions.	rom Abuse, Neglect, and re right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from nt, involuntary seclusion and mical restraint not required to medical symptoms.  ility must- use verbal, mental, sexual, or reporal punishment, or	F 600			1/13/20

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G		E SURVEY MPLETED
		495257	B. WING			C <b>11/2019</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		THE STATE OF THE S
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	by: Based on staff interest and clinical record facility staff failed to in the survey samp #9, were free from a.m., Resident #9 and Resident #8 the hand.  The findings include A "Facility Reported documented in part 11:30 AM. Resident (Resident #9). Injured documented next to Resident #9 approximates a sitting at table Resident #9 approximates a sitting at table Resident #9's regulated to move and Resident #9's regulated to move and Resident #8 concept to move and Resident #8 concept to move and Resident #8 slapper residents were immades a sessible to either resident. In initial FRI (facility reabuse regarding (Redocumented in part table in the activity	erview, facility document review review, it was determined the to ensure two of nine residents ple, Resident #8 and Resident abuse. On 8/8/19 at 11:30 slapped Resident #8's hand nen slapped Resident #9's	F 600	1. Residents #8 and #9 both in facility and have had no addincidents. 2. All residents have the pote affected by this alleged deficier 3. All staff will be educated or Abuse and Neglect Policy and Manual, specifically as it relateresident to resident incidents a window to report. 4. Facility will monitor all incidents all potential for abuse, to ensure in and reporting of incidents. Incidence weeks, and then 3 times a week weeks, and then 1 time a week weeks to ensure that all potential dentified and reported as requivariances will be corrected at the observation, education and corrections will be provided as need Ongoing compliance will be more part of the facility's QA process months. 5. Corrective action will be contained.	ential to be ant practice. In the facility Procedure is to and the dents buse, or investigation dents is a week is for 2 is for 4 ial abuse is ired. The time of crective ded. Conitored as is for 3	

AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495257	B. WING		12	C / <b>11/2019</b>
	PROVIDER OR SUPPLIER	CREEK		STREET ADDRESS, CITY, STATE, ZIP CO 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	regular spot. Resident #8 kicked residents began yer Resident #8 cursing slapped Resident # slapped Resident # slapped Resident # cursing at each other the residents were nursing, and there altercation. Both realtercation. Both realtercation. Both realtercation and the evaluated by psychology of the altercation practitioner) felt the continued danger to monitoring of both hours without addit discontinued."  Resident #8 was an 12/30/14 with diagrant limited to: diver pouch like sacs three colon) (1), epile convulsive seizures production of hemology.  The most recent M assessment, a qual ARD (assessment, a qual ARD (assessment indicating the resident BIMS (brief intervieindicating the resident extensive assistant extensive extensive assistant extensive extensive assistant extensive assistant extensive assistant extensive extensive assistant extensive extensive assistant extensive extensive assistant extensive exten	dent #8 declined to move and Resident #8's chair. Both Illing at each other with g at Resident #9. Resident #9 8's hand, then, Resident #9 8's hand. Both residents were er throughout the interaction. It is separated and evaluated by were no injuries from the esidents were started on every by facility initially and were diatric nurse practitioner on the on. The NP (nurse at neither resident presented a positional incident and was then dimitted to the facility on the incident and was then district the incident and was then districted to the facility on the incident and was then districted to the facility on the incident and was then districted to the facility on the incident and was then districted to the facility on the incident and was then districted to the facility on the incident and was then districted to the facility on the incident and was then districted to the facility on the incident and was then districted to the facility on the incident and was then districted to the incident and every dent was second and every dent was second and every dent was coded as requiring the incident and the incident and every dent was coded as requiring the incident and the incident an	F 60	00		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY
		495257	B. WING _		12	C 2/11/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 600	A review of the condocumented in para "At risk for advers psychoactive med 5/4/18 "Resident overbal behavioral towards others-be interfere with partial and has potential. The Interventions: behavioral episod stressor, may eat stimulation. Emph following treatment as appropriate and A nurse progress or record dated 8/8/1 "Resident to reside room with both reseach other's hands (Resident #9) asking of his spot. Resident (Resident #9) asking for his spot. Resident #9 was a AM, with Resident #9 was a 11/26/16 with diagrillimited to: demential decline) (4), intraction amount of blood with the spot with the spot and the spot an	mprehensive care plan art, The Focus: dated 2/20/18 e effects related to lication." The Goal: dated demonstrates presence of disturbance symptoms directed chaviors has potential to cipation in social interactions to disrupt living environment." dated 5/7/18 "During es- staff to remove guest from meals in room for decreased hasize the positive aspects of at regimen. Encourage activities desired for diversion."  note in Resident #8's clinical 9 at 11:45 AM, documented, ent altercation in the activity sidents cursing and slapping s. This was in response to ng (Resident #8) to move out ents on every 15-minute	F 60			

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	PROVIDER OR SUPPLIER	CREEK		STREET ADDRESS, CITY, STATE, ZIP CO 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		7172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	The most recent M assessment, a qual ARD (assessment toded the resident BIMS (brief intervision indicating the resident particle. The resident extensive assistant locomotion on and toilet use and personal toilet use and personal towards other resident and toilet use and personal towards other resident in care and will cauthrough next review 2/5/18 "Provide a depisodes of increas [medications] as on necessary to prote others. Divert attendand take to alternate A nurse progress mand take to alternate A nurse progress mand take to alternate and take to resident to re	DS (minimum data set) Interly assessment, with an reference date) of 11/2/19, as scoring a 8 out of 15 on the ew for mental status) score, ent was moderately cognitively dent was coded as requiring ce for bed mobility, transfer, off the unit, dressing, eating, onal hygiene.  In prehensive care plan the foliation of the Goal: dated 2/5/18 and aggression dents. The Goal: dated 2/5/18 and and effects on resident's ced by continuing to participate use no harm towards others with The Interventions: dated quiet environment during sed anxiety. Administer meds and the rights and safety of antion. Remove from situation the location as needed. The foliation of the continuity of t	F 60			

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII		ONSTRUCTION		MPLETED
		495257	B. WING			1:	C <b>2/11/2019</b>
	PROVIDER OR SUPPLIER			1161	EET ADDRESS, CITY, STATE, ZIP CODE 1 ROBIOUS ROAD LOTHIAN, VA 23113		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 600	AM, with CNA (cer When asked to de stated, "It is physic someone." When to an allegation of CNA #1 stated, "It residents and mak would notify their rathe chain to be inverted the End of the chain to be inverted to End of the chain to be inverted to End of the chain to be inverted to the chain to the	rtified nursing assistant) #1. escribe signs of abuse, CNA #1 cally or verbally assaulting asked how she would respond abuse or witnessing abuse, would first separate the ase sure they weren't hurt. Then I manager, who would pass it up estigated." When asked if she 8/8/19 incident between assident #8, CNA #1 stated,	F 60	00			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF			E SURVEY PLETED
		495257	B. WING			0 11/2019
	PROVIDER OR SUPPLIER	REEK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	12	11/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607 SS=D	Non-Medical Reader Chapman, page 19 (3) Barron's Diction Non-Medical Reader Chapman, page 32 (4) Barron's Diction Non-Medical Reader Chapman, page 15 (5) Barron's Diction Non-Medical Reader Chapman, page 26 (6) Barron's Diction Non-Medical Reader Chapman, page 32 Develop/Implement CFR(s): 483.12(b) (1) §483.12(b) (1) Prohing Personal Properties of Season Se	ary of Medical Terms for the er, 7th edition, Rothenberg and 9. ary of Medical Terms for the er, 7th edition, Rothenberg and . ary of Medical Terms for the er, 7th edition, Rothenberg and 4. ary of Medical Terms for the er, 7th edition, Rothenberg and 6/304. ary of Medical Terms for the er, 7th edition, Rothenberg and 6/304. ary of Medical Terms for the er, 7th edition, Rothenberg and . at Abuse/Neglect Policies 1)-(3) illity must develop and policies and procedures that: ibit and prevent abuse, tation of residents and aresident property, blish policies and procedures such allegations, and de training as required at	F 607		eside	1/13/20
	the facility staff fails policy for reporting	ed to implement the facility immediately, or within two of abuse to the State Agency,		incidents.  2. All residents have the potential affected by this alleged deficient pra	to be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	C	PLETED	
NAME OF I	PROVIDER OR SUPPLIE	B	1 5	STREET ADDRESS, CITY, STATE, ZIP CODE			
	JRELS OF WILLOW			1611 ROBIOUS ROAD MIDLOTHIAN, VA 23113			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 607	for two of nine re Resident #8 and a.m., Resident #8 hand. The reside reported to the S three hours and s occurred.  The findings inclu The facility's polic Investigation, and revision of 12/17, shall not allow ve abuse and all fac report any incide hitting, slapping, reporting of alleg caused the allega abuse, it should I immediately, but allegation is mad  A "Facility Report documented in p 11:30 AM. Reside (Resident #9). In documented nex Resident to resid (Resident #8) and was sitting at tab Resident #9 appr Resident #9's reg to move and Res chair. Both resid	sidents in the survey sample, Resident #9. On 8/8/19 at 11:30 9 slapped Resident #8's hand then slapped Resident #9's ent-to-resident altercation was tate Agency on 8/8/19 2:46 PM, sixteen minutes after the incident ude:  by "Abuse Prohibition, d Reporting" dated 4/17 with documents in part, "The facility broal, mental, sexual, or physical cility personnel will promptly ent. Physical abuse is defined as pinching, kicking etc. Initial ations of abuse: If the event that ation involves an allegation of the reported to the state no later than two hours after the	F 607	3. All staff will be educated on the Abuse and Neglect Policy and Prediction Manual, specifically as it relates the tresident to resident incidents and window to report.  4. Facility will monitor all incidents between residents to identify abuse potential for abuse, to ensure invand reporting of incidents. Incide reports will be reviewed 5 times a for 1 week, then 3 times a week to weeks, and then 1 time a week for weeks to ensure that all potential identified and reported as required Variances will be corrected at the observation, education and correlactions will be provided as needed Ongoing compliance will be monipart of the facility's QA process for months.  5. Corrective action will be comedited as a complete the comedited and reported as required to the facility's QA process for months.  5. Corrective action will be comedited as a complete the comple	occedure to If the Ints Isse, or estigation Isse, or estigati		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495257		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED C			
	THE LAURELS OF WILLOW CREEK			STREET ADDRESS, CITY, STATE, ZIP COL 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		12/11/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	Resident #8 slapper residents were immassessment of botto either resident. initiated on Reside Fax to the State Actification Virgin documented a data PM, result as being to reporting to the and sixteen minute. Resident #8 was a 12/30/14 with diagnot limited to: diverpouch like sacs that the colon) (1), epiliconvulsive seizure production of hemology.  Resident #8's mosset) assessment, a ARD (assessment coded the resident BIMS (brief intervisindicating the resident assistant locomotion on and toilet use and persident #8, document dated 2/20/18 "At the psychoactive mediated 2/20/18 "At the psychoactive mediated 2/20/18 "Resident dated 2/	ed Resident #8's hand, then, ed Resident #9's hand. The mediately separated. the residents revealed no injury Every 15-minute checks were ent #8 and Resident #9. The gency [Office of licensure and ia Department of Health] eltime as follows: 8/8/19 2:46 g OK. The time from incident State Agency was three hours es.  Idmitted to the facility on mosis that included but were riculitis (presence of abnormal rough the muscular layers of epsy (neurological disorder with s) (2), anemia (defect in the oglobin and the red blood cell)  It recent MDS (minimum data a quarterly assessment, with an reference date) of 10/4/19, as scoring a 9 out of 15 on the ew for mental status) score, dent was moderately cognitively dent was coded as requiring ce for bed mobility, transfer, off the unit, dressing, eating,	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495257			(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C 12/11/2019	
		495257	B. WING			
	PROVIDER OR SUPPLIE		1	STREET ADDRESS, CITY, STATE, ZIP CO 1611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		Time
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	towards others-beinterfere with partiand has potential. The Interventions behavioral episod stressor, may eat stimulation. Emploid following treatmer as appropriate and Resident #9 was a 11/26/16 with diaglimited to: dement decline) (4), intracamount of blood with (defect in the procred blood cell) (6). Resident's #9 moset) assessment, ARD (assessment, ARD (assessment, ARD (assessment indicating the resident BIMS (brief intervisindicating the resident BIMS (brief intervisindicating the resident assistant locomotion on and toilet use and personal toilet	ehaviors has potential to ticipation in social interactions to disrupt living environment." It disrupt living environment." It discusses the positive aspects of an admitted to the facility on gnosis that included but were not tia (progressive state of mental cranial hemorrhage (large within the cranium) (5), anemia duction of hemoglobin and the control of the facility on gnosis that included but were not to tia (progressive state of mental cranial hemorrhage (large within the cranium) (5), anemia duction of hemoglobin and the control of the model of 11/2/19, and as scoring a 8 out of 15 on the riew for mental status) score, ident was moderately cognitively sident was coded as requiring noce for bed mobility, transfer, doff the unit, dressing, eating,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495257	B. WING		C 12/11/2019		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		12/11/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	anxiety. Administer ordered. Intervenerights and safety on Remove from situation as needed. An interview was on PM with LPN (licer unit manager of the verify the FRI (facil 8/8/19 at 11:30 AM the date and time or reflect what occurr fax date and time or confirmation form stated, "Yes, that is On 12/10/19 at 4:3 staff member) #1, DON (director of neclinical coordinator director of operational coordinator director director d	er meds [medications] as as necessary to protect the fothers. Divert attention. In a stion and take to alternate attention and take to alternate attention and take to alternate attention.  It conducted on 12/10/19 at 2:00 ased practical nurse) #4, the expected wing. When asked to ity reported incident) dated attention, LPN #4 stated, "Yes, that is of the incident and the notes ed." When asked to verify the documented on the fax of 8/8/19 2:46 PM, LPN #4 at the date and time of the fax."  5 PM, ASM (administrative the administrator, ASM #2, the training), ASM #3, the regional and ASM #4, the regional and ASM #4, the regional and ASM #4 and Example and Example and ASM #4 and Example and ASM #4 and Example and ASM #4 and Example and	F 607				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		495257	B. WING _		12	2/11/2019	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
THE LAU	JRELS OF WILLOW O	CREEK		11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 607		43.7	F 60	07			
F 609 SS=D	Non-Medical Read Chapman, page 26 (6) Barron's Diction Non-Medical Read Chapman, page 32	nary of Medical Terms for the er, 7th edition, Rothenberg and 66/304. hary of Medical Terms for the er, 7th edition, Rothenberg and d.	F 60	09		1/13/20	
		onse to allegations of abuse, n, or mistreatment, the facility					
	involving abuse, ne mistreatment, inclu source and misapp are reported immed hours after the alleg that cause the alleg serious bodily injury the events that cau abuse and do not rethe administrator of officials (including tradult protective serfor jurisdiction in lor accordance with Staprocedures.  §483.12(c)(4) Reporting the serious forms and the serious	are that all alleged violations reglect, exploitation or ding injuries of unknown repriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if see the allegation do not involve result in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides and the results of all readministrator or his or her notative and to other officials in read alleged violation is verified ve action must be taken.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495257	B. WING			C <b>12/11/2019</b>	
	PROVIDER OR SUPPLIER	CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113			172010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 609	This REQUIREME by: Based on staff interest and clinical record the facility staff failer abuse immediately Agency, for two of sample, Resident # The findings include A "Facility Reported documented in part 11:30 AM. Resident (Resident #9). Injurt documented next to Resident to resider (Resident #8) and twas sitting at table Resident #9 approaches a sitting at table Resident #9's regult to move and Resident #9's regult to move and Resident #8 con Resident #8 con Resident #8 slapper residents were immediately approaches were immediately approaches to the State Ag Certification Virginic documented a date PM, result as being to reporting to the Stand sixteen minute and sixteen minute.	erview, facility document review review, it was determined that ed to report an allegation of or within 2 hours, to the State nine residents in the survey and Resident #9.  The incident dated, 8/8/19, time the involved (Resident #8) and ries: (A check mark was only "No." Describe Incident: altercation between (Resident #9). Resident #8 in the activity room when eached from behind and asked by because he was sitting in lar spot. Resident #8 declined ent #9 kicked Resident #8's ats began yelling at each other cursing at Resident #9. The nediately separated. In residents revealed no injury Every 15-minute checks were not #8 and Resident #9. The pency [Office of licensure and a Department of Health] extime as follows: 8/8/19 2:46 grow. The time from incident state Agency was three hours	F 60	1. Residents #8 and #9 bot in facility and have had no ad incidents. 2. All residents have the postfected by this alleged deficition 3. All staff will be educated Abuse and Neglect Policy an Manual, specifically as it relaresident to resident incidents window to report. 4. Facility will monitor all incidents window to report. 4. Facility will monitor all incidents window to report. 4. Facility will monitor all incidents to identify potential for abuse, to ensure and reporting of incidents. Increports will be reviewed 5 times for 1 week, then 3 times a we weeks, and then 1 time a we weeks to ensure that all pote identified and reported as reconstruction, education and constitutions will be provided as not ongoing compliance will be reported to the facility's QA procemonths. 5. Corrective action will be 1/13/2020	tential to be ient practice. on the facility d Procedure tes to and the cidents abuse, or e investigation cidents nes a week eek for 2 ek for 4 ntial abuse is quired. It the time of corrective eeded. monitored as iss for 3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  C 12/11/2019	
		495257				
	NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF WILLOW CREEK			TREET ADDRESS, CITY, STATE, ZIP CO 1611 ROBIOUS ROAD IDLOTHIAN, VA 23113		
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F 609	Investigation, and revision of 12/17, shall not allow verabuse and all faci report any incider hitting, slapping, preporting of allegal caused the allegal abuse, it should be immediately, but allegation is made.  Resident #8 was 12/30/14 with diagnot limited to: diveyouch like sacs the colon) (1), epiconvulsive seizur production of here (3).  Resident #8's moset) assessment, ARD (assessment, ARD (assessment, ARD (assessment) (assessment) (assessment) (brief intervindicating the resimpaired. The resextensive assistated locomotion on an toilet use and per A review of the color (assessment) (assessm	Reporting" dated 4/17 with documents in part, "The facility rbal, mental, sexual, or physical ility personnel will promptly it. Physical abuse is defined as binching, kicking etc. Initial ations of abuse: If the event that ition involves an allegation of the reported to the state in later than two hours after the etc."  admitted to the facility on gnosis that included but were exticulitis (presence of abnormal inrough the muscular layers of illepsy (neurological disorder with es) (2), anemia (defect in the moglobin and the red blood cell)  st recent MDS (minimum data a quarterly assessment, with an at reference date) of 10/4/19, in the assoring a 9 out of 15 on the iew for mental status) score, ident was moderately cognitively ident was coded as requiring ince for bed mobility, transfer, d off the unit, dressing, eating,	F 609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495257	B. WING		12/11/2019	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113			1112010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	interfere with partic and has potential to The Interventions: behavioral episode stressor, may eat a stimulation. Emph following treatment as appropriate and Resident #9 was a 11/26/16 with diaglimited to: dementic decline) (4), intract amount of blood w (defect in the produced blood cell) (6).  Resident's #9 most set) assessment, a ARD (assessment coded the resident BIMS (brief intervial indicating the resident BIMS (brief intervial indicating the resident assistant locomotion on and toilet use and personal toilet use and personal toward dated 2/5/18 "Anxionation of the cornesident #9, document dated 2/5/18 "Anxionation of the cornesident #9, do	cipation in social interactions to disrupt living environment." dated 5/7/18 "During es- staff to remove guest from meals in room for decreased tasize the positive aspects of tregimen. Encourage activities desired for diversion."  dmitted to the facility on mosis that included but were not a (progressive state of mental ranial hemorrhage (large ithin the cranium) (5), anemia uction of hemoglobin and the trecent MDS (minimum data a quarterly assessment, with an reference date) of 11/2/19, as scoring a 8 out of 15 on the lew for mental status) score, lent was moderately cognitively dent was coded as requiring ce for bed mobility, transfer, off the unit, dressing, eating,	F 609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495257		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED  C 12/11/2019		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 609	as necessary to proothers. Divert atter and take to alternat An interview was comply with LPN (licen unit manager of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the FRI (facili 8/8/19 at 11:30 AM) the date and time document of the verify the	britect the rights and safety of ontion. Remove from situation the location as needed."  Inducted on 12/10/19 at 2:00 sed practical nurse) #4, the exwest wing. When asked to dity reported incident) dated at LPN #4 stated, "Yes, that is of the incident and the notes ed." When ask to verify the fax amented on the fax of 8/8/19 2:46 PM, LPN #4 the date and time of the fax."  In PM, ASM (administrative the administrator, ASM #2, the arsing), ASM #3, the regional and ASM #4, the regional and ASM #6, the arry of Medical Terms for the er, 7th edition, Rothenberg and 9.  The arry of Medical Terms for the er, 7th edition, Rothenberg and arry of Medical Terms for the er, 7th edition, Rothenberg and 4.  The arry of Medical Terms for the er, 7th edition, Rothenberg and 4.  The arry of Medical Terms for the er, 7th edition, Rothenberg and 4.  The arry of Medical Terms for the er, 7th edition, Rothenberg and 4.  The arry of Medical Terms for the er, 7th edition, Rothenberg and 4.  The arry of Medical Terms for the er, 7th edition, Rothenberg and 4.  The arry of Medical Terms for the er, 7th edition, Rothenberg and 4.	F 60			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		495257	B. WING		12	2/11/2019	
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F 656 SS=D	(6) Barron's Diction Non-Medical Read Chapman, page 32 Develop/Implement CFR(s): 483.21(b) (1) \$483.21(b) (1) The implement a compression of the implement and the implementation of the implementation	ary of Medical Terms for the er, 7th edition, Rothenberg and and a to Comprehensive Care Plan 1)  The ensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and includes measurable eframes to meet a resident's and mental and psychosocial attified in the comprehensive comprehensive care plan must ing - at are to be furnished to attain ident's highest practicable and psychosocial well-being as 13.24, §483.25 or §483.40; and at would otherwise be required 13.25 or §483.40 but are not a resident's exercise of rights and the right to refuse 183.10(c)(6). If services or specialized the services of rights are services or specialized the services or specialized	F 6			1/13/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	whether the resider community was as local contact agend entities, for this pur (C) Discharge plant plan, as appropriate requirements set for section.  This REQUIREMENT by:  Based on observations staff interview, it was failed to implement for one of nine residents # 4. The implement Residents # 4. The implement Resident plan to change the needed on 12/10/19.  The findings include Resident # 4 was a diagnoses that including holood pressure failure and obesity.  Resident # 4's moss set), an admission a (assessment reference Resident # 4 as social interview for mental 15, 15 - being cog decisions. Resident of activities of daily living Bowel Resident # 4 incontinent of bower interview for mental 15, 15 - being cog decisions. Resident # 4 incontinent of bower incontinent of bower incontinent of bower interview for mental 15, 15 - being cog decisions. Resident # 4 incontinent of bower incontinent of bower incontinent of bower interview for mental 15, 15 - being cog decisions. Resident # 4 incontinent of bower incontinent of bower incontinent of bower interview for mental 15, 15 - being cog decisions. Resident # 4 incontinent of bower interview for the formula in the f	ont's desire to return to the sessed and any referrals to be sessed and any referrals the comprehensive care plant dents in the survey sample, facility staff failed to be suffered as to the survey sample, facility staff failed to be suffered as the survey and as sessed and survey and as sessed and survey and as sessed and survey and sur	F 65	1. Resident #4 still resides in and has had a toileting schedul implemented. 2. All residents requiring assis incontinence care have the pote affected by this alleged deficient. 3. All nursing staff will be educ providing timely incontinence cat. DON or designee will conduct audits on 10 residents requiring incontinence 5 times a week for 2 week once weekly for 2 weeks to ensincontinence care is provided. It will be corrected at the time of observation, education and corrections will be provided as need Ongoing compliance will be mothrough routine audits and will be to the facility's QA committee for months. 5. Corrective action will be cor 1/13/2020	tance for ential to be to practice. eated on are. and then are timely ariances ective led. initored e reported r 3	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED	
		495257	B. WING _		12	/11/2019
	NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF WILLOW CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 656	dated 11/19/2019 of # 4] is incontinent of Date Initiated: 11/1 it documented, "BF 3XL [three extra-la frequently and prn 11/19/2019."  On 12/10/19 at 11: conducted with Re interview, Residen soiled. When asked or a staff member stated that she told assistant] at 10:45  On 12/10/19 at 12: conducted with CN Resident # 4 was of stated yes. When incontinence care, her at 10:30 [a.m.] me back in and sa again. I told her I whad just changed if find two other staff can't move to help had the conversation of the situation. If myself and it would if Resident # 4 had of now, CNA # 1 state finishes eating dignified to leave F since 10:45 a.m., of else could I do about On 12/10/19 at 12:	documented, "Need: [Resident of B&B [bowel and bladder]. 9/2019." Under "Interventions" RIEF USAGE: Resident uses rge] disposable briefs. Change [as needed. Date Initiated:  00 a.m., an interview was sident # 4. During the t # 4 stated that her brief was ed if the call bell was activated was notified, Resident # 4 ther CNA [certified nursing a.m.  30 p.m., an interview was IA # 1. When asked if on their caseload, CNA # 1 asked about Resident # 4's CNA # 1 stated, "I changed and she [Resident # 4] called id she needed to be changed would get to her after lunch. I her and I didn't want to go and to change her again. She and I don't know if anyone has on with her to tell her the reality she could roll I could do it dn't be an issue." When asked I received incontinence care as stated, "No, I'll change her after I." When asked if it was Resident # 4 in a soiled brief CNA # 1 stated, "No but what	F 65	6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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****	PROVIDER OR SUPPLIER	CREEK		STREET ADDRESS, CITY, STATE, ZIP COD 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		2/11/2019	
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F 656	manager. When a for providing incontinence care of incontinence care is informed a reside changing, RN # 1 sto 30 minutes." Wi important to provide manner, RN # 1 stabreakdown and uring On 12/10/19 at 2:00 conducted with RN the purpose of the # 1 stated, "We know what interventions a Resident # 4's care RN # 1 was asked was being followed approximately two care. RN # 1 stated part."  On 12/10/19 at 12:30 conducted with Resident # 4 was pat 1:00 p.m.  On 12/10/19 at 2:30 conducted with Resident # 4 was pat 1:00 p.m.	sked to describe the procedure inence care, RN # 1 stated, uld be checked every two ble to tell us if they need or not." When asked how soon should be provided when staff ent requires care and stated, "As soon as you can, 20 men asked why it was a incontinence care in a timely ated, "To prevent skin mary tract infections."  Dip.m., an interview was # 1. When asked to describe comprehensive care plan, RN ow what the patient needs and are in place." After reviewing a plan for incontinence care, if the comprehensive care plan by having Resident # 4 wait hours to receive incontinence d, no. Not the prn [as needed]  Dip.m., an interview was sident # 4. When asked if she tinence care Resident # 4  Dip.m., CNA # 1 stated that rovided with incontinence care	F 65	56			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP  A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	REEK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		har day
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	(administrative staf administrator, ASM # 3, regional clinica regional director of of the findings.	f member) # 1, the # 2, director of nursing, ASM I coordinator and ASM # 4, operations, were made aware ion was provided prior to exit.	F 656			1/10/00
F 677 SS=D	S483.24(a)(2) A resout activities of dail services to maintain personal and oral harmonic personal and observation assistance to maintone of nine resident personal p	sident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced tion, resident interview and as determined that facility staff tivities of daily living tain good personal hygiene for ts in the survey sample, sident #4, who is coded as for activities of daily living, and nursing assistant) #1 she are care at 10:45 a.m. CNA #1 istance to Resident #4 until the resident was changed.	F 677	1. Resident #4 still resides in the fand has had a toileting schedule implemented. 2. All residents requiring assistance incontinence care have the potential affected by this alleged deficient proceeding timely incontinence care. 3. All nursing staff will be educated providing timely incontinence care. 4. DON or designee will conduct reaudits on 10 residents requiring incontinence 5 times a week for 1 withen 3 times a week for 2 weeks an once weekly for 2 weeks to ensure incontinence care is provided. Variate will be corrected at the time of observation, education and correctinactions will be provided as needed. Ongoing compliance will be monitored through routine audits and will be reto the facility's QA committee for 3 months. 5. Corrective action will be completed.	ce for al to be actice. d on andom week, ad then timely ances ve	1/13/20

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495257	B. WING		11	C 2/11/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		2/1//2019
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 677	Resident # 4 as so interview for ment - 15, 15 - being codecisions. Reside totally dependent activities of daily li Bowel" Resident # incontinent of bow On 12/10/19 at 11 conducted with Reinterview Residen soiled. When ask or a staff member stated that she tol assistant] at 10:45 On 12/10/19 at 12 conducted with CN Resident # 4 was stated yes. When incontinence care at 10:30 [a.m.] and said she needed the would get to her and I didn't was to change her agal I don't know if any with her to tell her she could roll I combe an issue." When received incontine stated, "No, I'll challed the she could roll I combe an issue." When received incontine stated, "No, I'll challed the she could roll I combe an issue." When received incontine stated, "No, I'll challed the she could roll I combe an issue." When received incontine stated, "No, I'll challed the she could roll I combe an issue." When received incontine stated, "No, I'll challed the she could roll I combe an issue." When received incontine stated, "No, I'll challed the she could roll I combe an issue." When received incontine stated, "No, I'll challed the she could roll I combe an issue." When received incontine stated, "No, I'll challed the she could roll I combe an issue." When received incontine stated, "No, I'll challed the she could roll I combe an issue."	coring a 15 on the brief al status (BIMS) of a score of 0 agnitively intact for making daily ent # 4 was coded as being of one staff member for ving. Section H "Bladder and 4 was coded as always rel and bladder.  :00 a.m., an interview was resident # 4. During the t # 4 stated that her brief was red if the call bell was activated was notified, Resident # 4 d her CNA [certified nursing	F 67	7 1/13/2020		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	COMPLETED
		495257	B. WING _		C 12/11/2019
	PROVIDER OR SUPPLIER	CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION
F 677	stated, "The reside two hours if they ar incontinence care of incontinence care informed a resident "As soon as you cated asked why it was in incontinence care instated, "To prevent tract infections."  On 12/10/19 at 12:: conducted with Residual received inconstated no.  On 12/10/19 at 1:4 surveyor that Residual received inconstated no.  On 12/10/19 at 2:3 conducted with Residual received with Residual received inconstated no.  The comprehensived dated 11/19/2019 of # 4] is incontinence constated 11/19/2019 of # 4] is incontinented. "BF 3XL 9three extra-la Change frequently Initiated: 11/19/201  On 12/10/19 at approximation (administrator, ASM # 3, regional clinical incontinence states administrator, ASM # 3, regional clinical incontinence states administrator, ASM # 3, regional clinical incontinence states administrator, ASM # 3, regional clinical incontinence states and incontinence states administrator, ASM # 3, regional clinical incontinence states and incontinence states	nts should be checked every e able to tell us if they need or not." When asked how soon should be provided when t requires care RN # 1 stated, in, 20 to 30 minutes." When inportant to provide in a timely manner RN # 1 skin breakdown and urinary  55 p.m., an interview was sident # 4. When asked if she tinence care Resident # 4  10 p.m., CNA # 1 told this dent # 4 was provided with at 1:00 p.m.  10 p.m., an interview was sident # 4. Resident # 4 stated are was provided at 1:00 p.m.  11 e care plan for Resident # 4  12 locumented, "Need: [Resident of B&B [bowel and bladder]. 13 left USAGE: Resident uses of B&B [bosoable briefs. and prn [as needed. Date 19 locumentely 4:35 p.m. ASM proximately 4:35 p.m. ASM	F 67	77	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED	
		495257	B. WING		11	C 2/11/2019	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113			12/11/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842 SS=D	S483.20(f)(5) Residing A facility may no resident-identifiable (ii) The facility may resident-identifiable accordance with a agrees not to use of except to the extent to do so.  §483.70(i) Medical §483.70(i) (1) In accordance with a second standard must maintain medical that are- (i) Complete; (ii) Accurately docu (iii) Readily access (iv) Systematically §483.70(i)(2) The fall information contregardless of the forecords, except who (i) To the individual representative who (ii) Required by Lat (iii) For treatment, operations, as permit with 45 CFR 164.5 (iv) For public heal neglect, or domest activities, judicial a law enforcement purposes, research medical examiners	dent-identifiable information. It release information that is the to the public. It release information that is the to an agent only in contract under which the agent or disclose the information the facility itself is permitted  records. Cordance with accepted ards and practices, the facility dical records on each resident  umented; ible; and organized  facility must keep confidential tained in the resident's records, orm or storage method of the the release is- the organized the resident  are permitted by applicable law; w; payment, or health care mitted by and in compliance	F 84			1/13/20	

	OF DEFICIENCIES  DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	COMPLETED
		495257	B. WING		12/11/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLÉTION
F 842	§483.70(i)(3) The record information unauthorized use. §483.70(i)(4) Med for- (i) The period of tii (ii) Five years from there is no require (iii) For a minor, 3 legal age under Si §483.70(i)(5) The (i) Sufficient inform (ii) A record of the (iii) The comprehe provided; (iv) The results of and resident revie determinations co (v) Physician's, nu professional's production (vi) Laboratory, raservices reports a This REQUIREME by: Based on staff intended in the cord for one of resample, Resident maintain an accurativing) documental.	facility must safeguard medical against loss, destruction, or ical records must be retained me required by State law; or in the date of discharge when ement in State law; or years after a resident reaches tate law.  medical record must containmation to identify the resident; resident's assessments; ensive plan of care and services any preadmission screening we evaluations and inducted by the State; irse's, and other licensed gress notes; and diology and other diagnostic is required under §483.50. ENT is not met as evidenced serview, facility document review if review, it was determined the to maintain an accurate clinical inine residents in the survey #6. The facility staff failed to ate ADL (activities of daily tion for Resident #6.	F 842	1. Resident #6 no longer resides facility. 2. All residents have the potentia affected by this alleged deficient p. 3. All nursing staff will be educat documenting ADL care on all residudits on 10 residents 5 times a v. 1 week, then 3 times a week for 2 and then once weekly for 2 weeks ensure ADL care has been documenting the statement of the s	al to be practice. ted on dents. trandom week for tweeks to

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	СОМ	E SURVEY PLETED
		495257	B. WING		12/	11/2019
THE LAURELS OF WILLOW CREEK  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			1	TREET ADDRESS, CITY, STATE, ZIP COI 1611 ROBIOUS ROAD IIDLOTHIAN, VA 23113	ODE	
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 842	5/31/19 with diagn limited to: Parkins progressive neuro by resting tremor, (1), dysphagia (imswallow) (2), gastrof the contents of esophagus caused sphincter muscle)  The most recent Massessment, an ad ARD (assessment not code the reside for mental status) as requiring extenderssing, toilet use resident was code eating. The reside occurred only once transfer, walk in roon/off the unit.  A review of the base for Resident #6, do "Pressure Sores/S"Prevent/heal pressure Sores/S"Preven	osis that included but were not son's Disease (slowly logical disorder characterized shuffling gait, slow movement) pairment in the ability to oesophageal reflux (backflow the stomach into the d by malfunction of the	F 842	Variances will be corrected at observation, education and coactions will be provided as ne Ongoing compliance will be not through routine audits and will to the facility's QA committee months.  5. Corrective action will be continued to the second	orrective reded. nonitored Il be reported for 3	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION		E SURVEY MPLETED
		495257	B. WING			C /11/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	1 12	11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICS)	D BE	(X5) COMPLETION DATE
F 842	individual bowel/bla "Start continence tr every two hours, ob area: "Cardiac/Res complications." Inte as indicated, diet as and report complicat for edema and report complaints of head endurance."  Resident #6's ADL documentation report the following: ADL Care- three of documented Bed mobility- three documented Dressing- three of redocumented Behavior monitoring was not documente Locomotion on unit were not document Locomotion off unit was not documented Personal hygiene-th not documented Shower/bath- three documented Toilet use and contine opportunities was no Transferring- three documented Eating- three of nine documented An interview was contined An interview was contined An interview was contined  An interview	adder routine." Interventions: acking form, incontinent care observe skin." Additional Focus opiratory." Goal: "No erventions: "Obtain vital signs ordered, observe endurance ations as indicated, observe for ache/dizziness/change in (activities of daily living) out for June 2019 documents nine opportunities were not of nine opportunities were not nine opportunities not gethree of nine opportunities ed three of nine opportunities ed one of nine opportunities was of nine opportunities was not nence- three of nine	F 842			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		TE SURVEY MPLETED	
		495257	B. WING		12	/11/2019	
	PROVIDER OR SUPPLIER	CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES · Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 842	unit manager of the what blank spaces form indicates, LPI means the CNA (or forgot to chart."  An interview was c AM with ASM (adm the director of nurs shown Resident #6 and asked what the #2 states, "If it's bla documented. The asked the standard facility, ASM #2 states and to reflect ongo tool for communicate members. Documentation incomissions, errors a lapse." (4)  On 12/11/19 at 10: staff member) #1, DON (director of nor regional clinical content to the above concerns to further information in the content to the above concerns the formation in the content to the above concerns the further information in the content to the above concerns the further information in the content to the above concerns the further information in the content to the above concerns the further information in the content to the above concerns the further information in the content to the above concerns the further information in the content to the above concerns the content to the above concerns the further information in the content to the above concerns the content to the above concerns the content to the content to the above concerns the content to the content	e west wing. When asked on the ADL documentation N #4 states, "If it's blank it ertified nursing assistant)  onducted on 12/11/19 at 10:10 ministrative staff member) #2, sing. When ASM #2 was b's ADL documentation form the blank spaces indicate, ASM ank it means it was not CNA didn't chart." When the of practice followed in the lated, "We use Lippincott."  Incott Nursing Procedures, the process of preparing a far patient's care and is a vital lation among health care team ent information as soon as the accuracy of the information ing care. Delayed reases the potential for and inaccuracy due to memory  45 AM, ASM (administrative the administrator, ASM #2, the ursing) and ASM #3, the ordinator was made aware of	F 84				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495257	B. WING		12	C /11/2019	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIR 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		711/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	Chapman, page 4 (2) Barron's Diction Non-Medical Rear Chapman, page 1 (3) Barron's Diction Non-Medical Rear Chapman, page 2	135. onary of Medical Terms for the der, 7th edition, Rothenberg and	F	342			