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 06/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated survey was conducted 6/13/17 through 6/15/17. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 106 at the time of the survey. The survey sample consisted of 4 current resident reviews (Residents #3 through #6) and 2 closed record reviews (Residents #1 and #2).	F 000		
F 164 SS=D	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,	F 164		7/28/17

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

Electronically Signed | 06/30/2017

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F 164	Continued From page 1 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide personal privacy during the provision of care for 1 of 6 residents in the survey sample; Resident #6 The facility staff left the door to the room open while providing wound care to Resident #6's right foot. Facility staff and residents were observed passing by the room and glancing into the room during Resident #6's wound care The findings include: Resident #6 was admitted to the facility on	F 164	The Laurels of Willow Creek wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is July 28, 2017. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F Tag 164	

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F 164	Continued From page 2 3/17/15 with the diagnoses of but not limited to: dementia, high blood pressure, end stage renal disease, dialysis, hypothyroidism, colon cancer, diabetes, and hip fracture. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/17/17. The resident was coded as being cognitively intact, scoring a 13 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring extensive assistance for bathing, hygiene, and dressing; limited assistance for transfers and eating; and as usually continent of bowel and bladder. On 6/15/17 at 9:39 a.m., LPN (licensed practical nurse) #5 was observed providing wound care to Resident #6's heel wound. During this process, it was noted that LPN #5 did not close the blinds to the window (Resident #6 was in window bed) which had visual sight of the parking lot; she did not close the curtain between Resident #6 and the roommate (who was up, awake, and observing the wound care as well), and she did not close the door to the room. Facility staff and residents were observed passing by the room and glancing into the room during Resident #6's wound care. On 6/15/17 at 9:54 a.m., after the wound care was completed, Resident #6 was asked if it bothered her that the door, curtains, and blinds were open during the wound care. She stated that it did not; that it wasn't like her pants were down. She stated if that was the case, then yes it would have. On 6/15/17 at 10:35 a.m., in an interview with LPN #5 (the Director of Nursing (DON) was	F 164	Privacy is now being provided for resident #6 and all other residents during wound care treatments. The Director of Nursing/designee will provide in-service education to all nursing staff on the provision of privacy to residents during treatments. The Director of Nursing will conduct rounds twice per week for 4 weeks to observe the provision of privacy during wound treatments. Corrections and additional training will be provided as indicated. Continued compliance will be monitored through random observations of resident privacy. Any variances will be reported to the DON, and the DON will report to the QA Committee. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 28, 2017.	

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F 164	Continued From page 3 present as well.) When asked about the above privacy concerns, LPN #5 stated she had asked the resident, before the surveyor arrived to the room, about the window blinds. LPN #5 stated the resident didn't want them down. She stated that Resident #6 and her roommate were best of friends and they never want the curtain pulled between them. LPN #5 stated that in the past when the curtain was pulled for the provision of care, the residents in the room questioned the curtain being pulled and asked that it not be. LPN #5 stated she definitely should have closed the door to the room to prevent other residents from observing the wound care that was provided. A review of the facility policy, "Dressing Change - Clean Technique" documented, "...5. Explain procedure and provide privacy..." On 6/15/17 at 10:35 a.m., the DON (Administrative Staff Member #2) was made aware of the findings. No further information was provided by the end of the survey. "Privacy and Confidentiality: The person has the right to personal privacy. This includes using the bathroom in private and all personal care measures. The person's body is exposed only as needed. Only staff involved in the person' care are present...Each person has the right to full visual privacy...." Mosby's Essentials for Nursing Assistants, 3rd edition, Sorrentino and Gorek, Pages 7 and 183.	F 164		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	F 280		7/28/17

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F 280	Continued From page 4 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280		

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F 280	Continued From page 5 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 280		

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F 280	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to review and revise the comprehensive care plan after a fall for one of 6 residents in the survey sample; Resident #4. The facility staff failed to revise Resident #4's comprehensive care plan to include newly implemented interventions after a fall on 4/29/17. The findings include: Resident #4 was admitted to the facility on 10/18/16 with the diagnoses of but not limited to: congestive heart failure, menieres disease, dementia, depression, acute kidney failure and pneumonia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/8/17. The resident was coded as being moderately cognitively impaired in ability to make daily life decisions, scoring an 8 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, and hygiene; supervision for eating; and as incontinent of bowel and bladder. A nurse's note dated 4/29/17 documented Resident #4 had a fall in activities from her wheel chair and sustained a skin tear. A review of the clinical record revealed a nurse practitioner's note dated 5/1/17 for the fall that occurred on 4/29/17. The nurse practitioner documented Resident #4 had a skin tear, and no	F 280	F Tag 280: The care plan for resident #4 was updated during the course of the survey to include newly implemented fall interventions. The MDS Coordinator/ designee will audit the MDS of all current residents related to fall interventions. Corrections will be made when appropriate. The DON/designee will in-service the MDS staff related to care plan updates for fall interventions. The MDS Coordinator / designee will review the care plans weekly for 4 weeks for residents with new falls to ensure that interventions are current. Variances will be corrected as identified, and concerns will be reported to the monthly quality assurance meeting. Continued education will be provided as needed. The MDS Coordinator /designee will continue to monitor for compliance through random review of care plan updates. Results of any variances will be reported to the DON and the DON will forward to the QA Committee. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 28, 2017.	

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F 280	Continued From page 7	F 280		

new orders.

A review of the internal incident report revealed Resident #4 was referred to therapy for wheel chair positioning. A dycem cushion was already in place, and was signed off on the TAR (Treatment Administration Record) as being in place approximately 1 hour before the fall.

A review of the care plan failed to reveal any evidence that it was updated to include the therapy screen.

On 6/15/17 at 1:00 p.m., in an interview with RN #2 (Registered Nurse) she stated, "The care plan is usually updated in morning meetings following any incident or change in condition." She reviewed the care plan and stated it (the care plan) did not appear to have been updated following the fall and the therapy screen was not added to the care plan after the 4/29/17 fall.

A review of the clinical record revealed that the therapy screen was completed on 5/2/17.

On 6/15/17 at 1:50 p.m., the DON (Director of Nursing), (Administrative Staff Member #2) stated there was no policy on revising and updating the care plan. She stated that the facility follows the RAI manual. (Resident Assessment Instrument).

No further information was provided by the end of the survey.

Chapter 4 of CMS's (Centers for Medicare and Medicaid Services) RAI Version 3.0 Manual documents the following information: "4.7 The RAI and Care Planning ....the comprehensive care plan is an interdisciplinary communication

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F 280	Continued From page 8 tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological 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...The care plan should be revised on an ongoing basis to reflect changes in the resident and the care the resident is receiving..."	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (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, clinical record review and facility document review, it was determined that the facility staff failed to follow professional standards of practice for one of 6 residents in the survey sample; Resident #5 The facility staff failed to clarify a physician's order for Resident #5's wound care. The findings include: Resident #5 was admitted to the facility on 3/2/17 with the diagnoses of but not limited to hip	F 281	F Tag 281: The wound care order for resident #5 has been clarified. The DON/designee will complete an audit of all current residents with orders for wound care to ensure that order clarifications are completed as needed. Any variances will be corrected and continued education provided. The DON/designee will complete in-service education with all licensed	7/28/17

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F 281	Continued From page 9 fracture, intra-abdominal abscess, colostomy, encephalopathy, septic shock, diabetes, hypothyroidism, high blood pressure, peripheral vascular disease, and glaucoma. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/27/17. The resident was coded as being moderately cognitively impaired in ability to make daily life decisions, scoring a 10 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, and hygiene; limited assistance for ambulation; supervision for eating; and as incontinent of bladder and had an ostomy for bowel. On 6/15/17 at 10:02 a.m., LPN #2 (Licensed Practical Nurse) #2 was observed providing wound care to Resident #5's stage 3 [1] open pressure wound to the right heel. During this observation, LPN #2 was not observed cleaning the heel prior to applying the new treatment and dressing. On 6/15/17 at 10:45 a.m., in an interview with LPN #2 (the DON (Director of Nursing [administrative staff member- ASM #2) was present as well.) When asked about cleansing the wound after removing the old dressing and applying the new treatment and dressing, LPN #2 stated that she followed the order. A review of the order dated 6/2/17 documented, "Treatment; Right heel - Dakins [2] wet to dry; Daily." The order did not specify to cleanse the wound first.	F 281	nursing staff on the proper completion and clarification of wound care orders. The DON/designee will review each new wound care order for the next 4 weeks to ensure completion and clarification. Variances will be corrected as identified and reported to the DON who will report trends to the QA Committee. On-going compliance will be monitored through the routine review of wound care orders and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 28, 2017.	

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F 281	Continued From page 10	F 281		

On 6/15/17 during the above interview, at 10:45 a.m., when asked if cleansing a wound after removing the old dressing and before applying the new dressing would be considered a standard of practice, ASM #2 stated it would be. ASM #2 stated the facility uses Lippincott as a professional reference.

On 6/15/17 at 1:20 p.m., an interview was conducted with RN #1 (Registered Nurse) who wrote the above order. RN #1 stated the order should have been clarified.

On 6/15/17 at 1:34 p.m., the DON stated that the facility did not have a policy on clarifying orders.

No further information was provided by the end of the survey.

Wound cleansing is performed to remove debris, contaminants, and excess exudate. Wound cleansers should not contain agents that are harmful to the cells involved in wound healing. Many commercial wound cleansers are available that contain agents such as surfactant, which may facilitate the removal of wound debris. Sterile normal saline is the cleansing solution of choice for chronic wounds. Fundamentals of Nursing 5th edition, Lippincott, Williams & Wilkins, page 1028.

[1] National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm

Stage III:
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not

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F 281	Continued From page 11 obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable. [2] Dakins solution is an antimicrobial solution used for wound management as an irrigant and a cleanser and as the wetting agent in a wet to moist dressing. Information obtained from https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=9906e5fe-7bf5-4d99-8107-c048bb5e42d5	F 281		