PRINTED: 10/06/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION  IILDING		(X3) DATE SURVEY COMPLETED	
		495257	B. WING _	B. WING		C 09/13/2023		
	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP C 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	ODE	, 50.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BITHE APPROPRIA		(X5) COMPLETION DATE	
E 000	Initial Comments		E	000				
F 000	survey was conducte 9/13/2023. The facilit compliance with 42 C Requirement for Long emergency prepared investigated during the INITIAL COMMENTS.  An unannounced Mesurvey was conducte Corrections are requirements. Three investigated during the (VA00057063-substate)	y was in substantial CFR Part 483.73, g-Term Care Facilities. No ness complaints were ne survey. Gedicare/Medicaid standard d 09/11/23 through 09/13/23. red for compliance with 42 al Long Term Care e complaints were ne survey ntiated with deficiency;	F	000				
F 550 SS=D	VA00056674-substar Life Safety Code sure. The census in this 12 116 at the time of the consisted of 30 curre seven closed record Resident Rights/Exer CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a rig self-determination, an access to persons ar outside the facility, in this section.	20 certified bed facility was survey. The survey sample nt resident reviews and reviews.  To cise of Rights (2)(b)(1)(2)  Rights.  Ight to a dignified existence, and communication with and and services inside and cluding those specified in	F	550			10/16/23 (X6) DATE	

Electronically Signed 10/05/2023

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.

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THE LAURELS OF WILLOW CREEK  11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550  Continued From page 1 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.  §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 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, resident interview, it was determined that the facility staff failed to promote dignity for one of 37 residents, Resident #24.  The findings include:  For Resident #24 (R24), the facility staff failed to rensure that they are treated with respect and dignity including incontinence care needs are met in himp manner by care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495257	B. WING		0	C <b>9/13/2023</b>	
	ROVIDER OR SUPPLIER	REEK		STREET ADDRESS, CITY, STATE, ZIP COD 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		3/10/2020	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 550	R24 was admitted that included but wasting and abnormal status of the scored 10 out of 1 for mental status, impaired of cognit Under Section H coded as being all On 09/11/23 at 12 revealed that R24 at the facility, activincontinence care On 09/11/23 at 12 revealed CNA (ceentered R24's roothe room with R24 On 09/11/2023 at revealed LPN (liceentered R24's roothe room with R24 On 09/12/23 at apinterview was connursing assistant)  When asked about approximately 12: stated that she pictoric sales.	at's dignity due to not providing e care.  Ito the facility with diagnoses were not limited to: muscle rmalities of gait and mobility.  It MDS (minimum data set), a ment with an ARD (assessment 06/20/2023, the resident 5 on the BIMS (brief interview indicating R24 was moderately ion for making daily decisions.  Bladder and Bowel" R24 was ways incontinent of urine.  Is p.m., an observation, who resided on the west unit wated the call bell for triffied nursing assistant) #2 m, turned off the call and left It's lunch tray.  Ito p.m., an observation ensed practical nurse) #4 m and provided incontinence	F 55	rounds.  3. Nursing staff and managers re-educated by October 9, 20 residents are treated with residignity including meeting incocare needs in a timely manne ADON/designee.  4. Department Managers/desiconduct audits of incontinent times weekly times 2 weeks, 2 weeks and monthly times 2 ensure residents are treated vand dignity including meeting care needs in a timely manne of the findings will be taken to months to ensure compliance follow the committee recomm	23 to ensure pect and intinence in by the signee will residents 3 weekly times months to with respect incontinence in A review of QAPI for 3 and will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		495257	B. WING				13/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	13/2023
				1	1611 ROBIOUS ROAD		
THE LAUF	RELS OF WILLOW CREE	≣K		N	MIDLOTHIAN, VA 23113		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 550	Continued From pag	e 3	F	550			
. 000		ld R24 that when she	'	550			
		ne meal trays she would					
		de incontinence care. When					
		finished picking up the meal					
		that it was after 1:00 p.m.					
	-	ne exact time. When asked					
		should wait for incontinence					
	•	a staff member, she stated					
		e right away so the resident					
	is not sitting in a soile	ed brief. When asked if					
	R24's was on their as	ssignment for Monday					
	9/11/2023, she stated	d yes. When informed of the					
	above observations a						
		nutes to receive incontinence					
	_	her call bell and informing					
		ted that she could have					
		at R24 required incontinence					
		it is dignified to have a					
		led brief for approximately 25					
	minutes, she stated i	10.					
	On 09/12/23 at appro	oximately 1:33 p.m., an					
		cted with LPN (licensed					
		ınit manager. When asked					
	how long a resident s	should wait for incontinence					
	care after informing a	a staff member, she stated					
		uld only have to wait within					
		hen informed of the above					
		stated that the CNA should					
	have let the nurse kn	•					
		Vhen asked if it is dignified to					
	have a resident wait						
	approximately 25 min	nutes, she stated no.					
	On 09/12/23 at appro	oximately 1:53 p.m., an					
		cted with LPN #4, MDS					
		if she entered R24's room					
	on Monday, 09/11/20	023 at approximately 1:00					
	p.m., she stated yes.						

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	ROVIDER OR SUPPLIER	К	•	110	REET ADDRESS, CITY, STATE, ZIP CODE 611 ROBIOUS ROAD IDLOTHIAN, VA 23113		
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F 550	stated that she proviot that the resident was that she was not awa waiting for incontinen just walked onto the udignified to have a refor approximately 25  On 09/13/2023 at appinterview was attemphow she felt being left not receive incontiner assistance, R24 states speak to the surveyor On 09/12/2023 at appinterview was attemphow she felt being left not receive incontiner assistance, R24 states speak to the surveyor On 09/12/2023 at appinterview was attemphow she felt being left not receive incontiner assistance, R24 states speak to the surveyor On 09/12/2023 at appinterview above findings.  No further information Notify of Changes (In CFR(s): 483.10(g)(14) Notific (i) A facility must immonsult with the residiconsistent with his or representative(s) where (A) An accident involves the injury and his physician intervention (B) A significant chanmental, or psychosocideterioration in health	led care to R24, LPN #4 led incontinence care, and wet. LPN #4 further stated re that R24 had been ce care because she had unit. When asked if it is sident wait in a soiled brief minutes, she stated no.  proximately 1:00 p.m., an ted with R24. When asked t in a wet brief when she did nce care when she asked for ed that she did not want to force when she asked for ed that she did not want to force when she asked for ed that she did not want to force when she asked for ed that she did not want to force when she asked for ed that she did not want to force when she asked for ed that she did not want to force when she asked for ed that she did not want to force when she asked for ed that she did not want to force when she asked for ed that she did not want to force when she asked for ed that she did not want to force when she asked for ed that she did not want to force when she asked for ed that she did not want to force when she asked for ed that she did force care when she asked for ed that she did force care when she did force care when she did force care when she did force and force when she did force care when she did force and force when she did force care when s		550			10/16/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495257	B. WING		C 09/13/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113	09/13/2023		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION		
F 580	clinical complications (C) A need to alter trea need to discontinue treatment due to advecommence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informatic is available and proviphysician. (iii) The facility must a resident and the resident	eatment significantly (that is, ean existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the else promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph . record and periodically mailing and email) and	F 58	1. Resident #225 (255) no longer re	sides		
		review, it was determined		in the facility. Resident #87 MD/NP h			

CENTERO   OR WEBTON RE & MEDION RE CENTROLE						1		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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		495257	B. WING				13/2023	
NAME OF P	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
THE LAND		-17		11	1611 ROBIOUS ROAD			
THE LAUF	RELS OF WILLOW CREE	:N		M	IIDLOTHIAN, VA 23113			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
TAG	REGULATORY OR	LOCIDENTII TING INI ONWATION)	IAG		DEFICIENCY)	AIL		
F 580	Continued From page	e 6	F	580				
		ailed to notify the physician			been notified that levothyroxine sodiur			
		red and/or administered, for			was not available on 9/10/23 and 9/11	/23.		
	two of 37 residents in							
	Resident #225 and R	desident #87.			2. An audit will be conducted of reside			
	The findings include:				who have had outside appointments in last 30 days to ensure new orders for	ııne		
	The infangs include.				medications have been communicated	l to		
	1. For Resident #22	5 (R225), the facility staff			the MD/NP. An audit will also be			
		ysician when a medication,			conducted to ensure residents on			
		rinary retention, from a			levothyroxine sodium medications are			
	consulting physician	was ordered.			available. Any concerns noted will be			
					communicated to the MD/NP.			
		vith diagnoses that included			O Linear ad Name and will be an adverse.			
	but were not limited the hyperplasia (1).	o benign prostatic			Licensed Nurses will be re-educated October 9, 2023 regarding residents was a second control of the contro	•		
	Tiyperpiasia (T).				have outside appointments returning v			
	A urology office visit i	note for R225 documented in			new orders for medications are	VICII		
		ffice visit: General. The			communicated to the MD/NP. Education	on		
	patient was accompa	nied by his son" Under			will also include notifying MD/NP of			
		y" it documented in part,			medications not available by the			
		ng (milligram) capsule			ADON/designee.			
	` ′	(one) capsule by mouth as			4 DONI/4	£		
		0 a.m.) daily." Under "Plan" ;, "We had a discussion			<ol> <li>DON/designee will conduct audits or residents who have outside appointment</li> </ol>			
		5-alpha reductase inhibitor			to ensure new orders for medications	11115		
	(3)"	o dipila roddotaee iiiiibitei			have been communicated to the MD/N	IP		
					and to ensure residents on levothyroxi			
	The prescription slip	from the urologist dated			sodium medications are available, if no	ot		
		m. documented in part,			MD/NP have been notified, in the clinic			
		capsule. Dispense 30 (thirty)			meeting 3 times weekly times 2 weeks			
		) capsule by mouth as			weekly times 2 weeks and monthly tim			
	directed at 9 AM daily	у.			2 months. A review of the findings will	pe		
	The facility physician	's order for R225			taken to QAPI for 3 months to ensure compliance and will follow the committee.	-66		
		"Dutasteride Capsule 0.5			recommendations.	.00		
		by mouth at bedtime for						
	benign prostatic hype							
	11/28/2022."							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495257	B. WING _	/ING		C 09/13/2023	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>-</u> <u>-</u> E	05/10	7/2020
THE ! ALIE	NEL O OF WILL OW ORES	14		11611 ROBIOUS ROAD			
THE LAUF	RELS OF WILLOW CREE	.K		MIDLOTHIAN, VA 23113			
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F 580	Continued From page	e 7	F 5	580			
	record) for R225 date	c medication administration d November 2022 revealed steride wasn't administered					
	11/28/2022 at 1:53 p.	r's (NP) note for R225 dated m., documented in part, n) Dutasteride added					
	dated 11/25/2022 throevidence documental	s nursing progress notes ough 11/27/2022 failed to cion of notification to the 225 consulting physician's					
	interview was conduct practical nurse) #8. We procedure when a resprescription for a medioutside of the facility should put order in cophysician or NP if the them to let them know prescription, put the sand call the pharmact available in the facility recalled R225 and who back to the facility from 11/25/2022 she stated R225 and his son car appointment between with a prescription for further stated she did	dication from a provider she stated that the nurse computer, talk to the y are in the building or call with the resident has a new script in the doctors book y if the medication is not y. When asked if they nen R225's son brought him m a urology appointment on diges. LPN #8 stated that me back from an a 7:00 p.m. and 8:00 p.m. a urinary retention. LPN #8 not call the physician.					
	interview was conduc	oroximately 11:00 a.m., an sted with ASM (administrative ector of nursing. When					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL' IDENTIFICATION NUMBER: A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	EEK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	1 00:10:2020
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 580	asked about R225 n when it was ordered stated that the resid the script was handed the pharmacy but diprovider. She furthenotified on the follow R225 received his find asked if there was a medication ASM #2 the physician or NP receive the medication.  On 09/13/2023 at as (administrative staff and ASM #2, direct aware of the above No further information obtained from the whittps://www.nlm.nih.statebph.html.  (2) Used alone or wittamsulosin [Flomax hyperplasia (BPH; egland). May reduce acute urinary retention obtained from the wind was a state of the second stat	not receiving Dutasteride If by the urologist, ASM #2 ent arrived around 8:00 p.m., ed to the nurse and faxed it to d not notify the on-call er stated that the NP was ving Monday, 11/28/2022, and rst dose that day. When If delay in R225 receiving his stated yes. When asked if was notified that R225 did not ion of Dutasteride she stated  Deproximately 3:00 p.m., ASM member) #1, administrator, or of nursing, were made findings.  Den was provided prior to exit.  State. This information was rebsite: Deproximately and prostatic enlargement of the prostate the chance of developing ion. This information was	F 580		

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F 580	to notify the physician levothyroxine sodium administration on 9/1/2 A review of R87's clin physician's order date sodium 75 mcg (micromouth in the morning review of R87's Septe (medication administr same physician's ord On 9/10/23 and 9/11/2 the code, "5=Hold/Se notes dated 9/10/23 amedication was not a cart. Further review of September 2023 MAI documentation that leadministered to R87 of failed to reveal documentation was notified On 9/12/23 at 3:20 p. conducted with LPN (LPN #3 stated the physician was discontinuous can give another order On 9/12/23 at 5:15 p. staff member) #1 (the	This information was besite: nih.gov/ R87), the facility staff failed in when the medication (1) was not available for 0/23 and 9/11/23.  Icical record revealed a ed 9/6/23 for levothyroxine ograms)- one tablet by for hypothyroidism. A ember 2023 MAR ration record) revealed the er for levothyroxine sodium. 23, the MAR documented the vailable in the medication of nurses' notes and the R failed to reveal evothyroxine sodium was on 9/10/23 and 9/11/23 and nentation that R87's d.  m., an interview was (licensed practical nurse) #3. ysician should be notified not available for se sometimes the physician	F 58	30			

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	ROVIDER OR SUPPLIER	к	1	TREET ADDRESS, CITY, STATE, ZIP CODE 1611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		
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F 580	(condition where the t produce enough thyro information was obtai	used to treat hypothyroidism hyroid gland does not oid hormone)." This	F 580			
F 585 SS=D	grievances to the faci that hears grievances reprisal and without for reprisal. Such grievar respect to care and tr furnished as well as the furnished, the behavior residents, and other of facility stay.  §483.10(j)(2) The resifacility must make proper resolve grievances the accordance with this place. §483.10(j)(3) The faci on how to file a grievato the resident.  §483.10(j)(4) The faci grievance policy to end all grievances regar contained in this para	ident has the right to voice lity or other agency or entity without discrimination or ear of discrimination has been entitled the second of staff and of other concerns regarding their LTC earlier to and the empt efforts by the facility to be resident may have, in paragraph.  Ility must make information ance or complaint available entitled in the prompt resolution reding the residents' rights graph. Upon request, the copy of the grievance policy	F 585			10/16/23
	(i) Notifying resident in	ndividually or through				

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F 585	facility of the right to facility of the right to facility of the right to facility of the grievance anonymous of the grievance anonymous of the grievance officing the grievance (mailing and number; a reasonable completing the review to obtain a written deagrievance; and the confide the filed, that is, the polymous office of the grievance and state Looprogram or protection (ii) Identifying a Grievance office of the facility; maintainformation associate example, the identity grievances submitted written grievance decordinating with state necessary in light of satisfies (iii) As necessary, take prevent further potenting all alleged of the grievance of the grievan	locations throughout the ille grievances orally in writing; the right to file usly; the contact information al with whom a grievance is or her name, business email) and business phone expected time frame for of the grievance; the right cision regarding his or her with whom grievances may entinent State agency, Organization, State Surveying-Term Care Ombudsman and advocacy system; ance Official who is beeing the grievance process, or grievances through to their any necessary investigations ining the confidentiality of all divith grievances, for of the resident for those anonymously, issuing isions to the resident; and e and federal agencies as specific allegations; ing immediate action to the individual of the provider, and of resident property, by rvices on behalf of the histrator of the provider; and	F	585			

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	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113		0/10/2020	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 585	include the date the grammary statement of the steps taken to invisuomary of the pertiin regarding the resident as to whether the gric confirmed, any correct taken by the facility and the date the writt (vi) Taking appropriat accordance with State of the residents' right or if an outside entity the State Survey Age Organization, or local confirms a violation for rights within its area of (vii) Maintaining evideresult of all grievance 3 years from the issuit decision.  This REQUIREMENT by:  Based on resident in facility document revireview, the facility state a grievance for one of sample, Resident #87  The findings include:  For Resident #87 (R8 resolve the resident's roommate.	written grievance decisions grievance was received, a of the resident's grievance, westigate the grievance, a nent findings or conclusions at's concerns(s), a statement evance was confirmed or not cive action taken or to be as a result of the grievance, are decision was issued; are corrective action in the law if the alleged violation as is confirmed by the facility having jurisdiction, such as ency, Quality Improvement all law enforcement agency for any of these residents' for responsibility; and the ence demonstrating the ence of the grievance.  This is not met as evidenced affectively, staff interview, sew and clinical record affectively in the survey.	F 58	1. Resident #87 has been madifferent room with satisfaction 2. An audit of grievance logs 30 days will be reviewed for the resolution as able.  3. Social Service staff and Adwill be re-educated by the RI by October 9, 2023 on ensur makes prompt efforts to reso grievances in a timely manner.  4. Administrator/designee will audits on ensuring the facility.	for the last timely dministrator DO/designee ing the facility live resident er.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495257	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	100201	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI	•	9/13/2023	
				11611 ROBIOUS ROAD	. —		
THE LAUF	RELS OF WILLOW CREE	K		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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 585	Continued From page	e 13	F 5	85			
	out of 15 on the BIMS status), indicating the intact for making daily On 9/11/23 at 2:48 p. conducted with the re	6 (brief interview for mental resident was cognitively decisions.  m., an interview was seident. R87 voiced concern		prompt efforts to resolve resi grievances with satisfaction i manner, if possible, 3 times v 2 weeks, weekly times 2 wee monthly times 2 months. A re findings will be taken to QAP	n a timely weekly times eks and eview of the I for 3		
	hours and bangs on t times throughout the this has occurred sind (on 8/1/23), her room the night, staff is awa	often agitated, swears for he snack table at different day and night. R87 stated be she moved into the room mate keeps her up during re, and no one has resolved time, R87's roommate was and loudly speaking		months to ensure compliance follow the committee recomm			
	for August 2023 and 3 grievance logs for Au 2023 failed to reveal resident's concern. N	gust 2023 and September documentation regarding the lurse practitioner notes and 9/1/23 documented R87					
	conducted with LPN ( (the unit manager). L complaints regarding she's not getting any spoke with R87's report the resident tends to and the nurses are re night. LPN #2 stated be in a bed by the wir didn't want to move, a available. LPN #2 sta grievance form regard spoke with the reside	c.m., an interview was flicensed practical nurse) #2 incensed practical nurse) #2 incensed practical nurse) #2 incensed practical nurse) #2 incensed practical nurse incenses					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	к		STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113	00/10/2020
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F 585	Continued From page	e 14	F 58	5	
	done to ensure R87's	on asked what has been grievance was resolved satisfied, LPN #2 stated she es that the resident is			
	officer). ASM #1 state residents, family mem grievance form then to down or morning mee #1 stated the grievance appropriate discipline responsible for invest developing a plan to the ASM #1 stated that at	(administrative staff inistrator and grievance ed that anyone including nbers or staff can fill out a he form is taken to the stand etings and discussed. ASM ce is then assigned to the			
	(the director of nursin above concern.	m., ASM #1 and ASM #2 g) were made aware of the			
F 641 SS=D	The facility policy title documented, "All con investigated, resolved Accuracy of Assessm CFR(s): 483.20(g)	cerns/grievances are d, and documented"	F 64	.1	10/16/23
	resident's status. This REQUIREMENT by: Based on staff intervi	of Assessments. t accurately reflect the is not met as evidenced iew and clinical record ned that the facility staff		Resident #103 MDS was modified to correctly code the discharge error to the correct to the discharge error to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495257	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	433237	1 2:		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	13/2023
NAIVIE OF P	ROVIDER OR SUPPLIER						
THE LAU	RELS OF WILLOW CRI	EEK			1611 ROBIOUS ROAD		
				M	IIDLOTHIAN, VA 23113		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page 15		F 6	641			
	failed to maintain a	n accurate MDS (minimum			hospital instead of to the community.		
		ent for one of 37 residents,			,		
	Resident #103.	,			2. An audit of discharged residents wh	0	
					have been discharged in the last 30 da		
	The findings include	e:			will be conducted to ensure the discha	rge	
					coding is correct. Any discharge reside		
	For Resident #103			noted to have discharge coding incorre	ct,		
	to code the dischar			will have the MDS modified and			
	ARD (assessment i			resubmitted as needed.			
	with the accurate d	scharge location.			2 MDC staff will be no advected by the		
	On the most recent	MDS, the discharge			<ol><li>MDS staff will be re-educated by the Administrator by October 9, 2023 on</li></ol>		
	assessment with ar			coding discharge residents correctly.			
	resident was coded			coding disoriarge residents correctly.			
	discharge to the co	- · · · · · · · · · · · · · · · · · · ·			4. Administrator/designee will conduct		
		,			audits 3 times weekly times 2 weeks,		
	The progress notes	for R103 documented in part,			weekly times 2 weeks and monthly tim	es	
	- "7/3/2023 19:16 (7	7:16 p.m.) Note Text: went to			2 months to ensure discharged resider	ıt	
		le awaiting return call from on			are coded correctly. Any MDS noted to		
		er], guest now c/o (complains			incorrect will have the MDS modified a		
		abdominal area, no specific			resubmitted as needed A review of the	<b>;</b>	
		e party) in room insisting guest			findings will be taken to QAPI for 3		
		et np (nurse practitioner) know			months to ensure compliance and will	_	
	family choice."	7:52 n m \ Note Toyt: snoke			follow the committee recommendations	š.	
		7:52 p.m.) Note Text: spoke age in condition and family					
	-	I to transfer to hospital per rp					
		uad in transporting guest to					
		accompanied by rp."					
	. ,						
	On 9/13/2023 at 8:4	41 a.m., an interview was					
		(registered nurse) #2, MDS					
		ed that they had daily clinical					
		s skilled residents, discuss					
		planned discharges and					
		ur reports to find out any					
		e discharged or transferred to					
		eviewed R103's discharge of 7/3/2023 and the progress					
	I MIDS WILL LITE ARD	or moreoes and the progress	1	- 1			1

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	к	,	STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113	1 00/10/2020	
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F 641	was not correct and s they went to the hosp MDS needed to be co they followed the RAI instrument) manual w assessments.  According to the RAI October 2018, section	and stated that the MDS should have been coded that ital. She stated that the prrected. She stated that (resident assessment when completing the MDS  Manual, Version 1.16, dated in A2100: OBRA Discharge	F 64	.1		
	Status, documented in Assessment: 1. Review including the discharge for documentation of 01, community (private assisted living, group is a private home, apparaised living facility, acute hospital: if disclinstitution that is engage under the supervision diagnostic services, the	n part, "Steps for ew the medical record ge plan and discharge orders discharge locationCode te home/apt., board/care, home): if discharge location artment, board and care, or group home Code 03, harge location is an aged in providing, by or of physicians for inpatients, herapeutic services for ad the treatment and care of				
		a.m., ASM (administrative administrator was made .				
F 656 SS=E	Develop/Implement C	n was provided prior to exit. Comprehensive Care Plan (3)	F 65	66	10/16/23	
	implement a compreh care plan for each res	ensive Care Plans cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		495257	B. WING _		0	C <b>9/13/2023</b>	
	ROVIDER OR SUPPLIER	:K		STREET ADDRESS, CITY, STATE, ZIP COD 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		0/10/2020	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 656	medical, nursing, and needs that are identification assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the rounder §483.10, including treatment under §483. (iii) Any specialized sere abilitative services provide as a result of recommendations. If findings of the PASAI rationale in the reside (iv) In consultation wit resident's representa (A) The resident's goodesired outcomes.  (B) The resident's prefuture discharge. Fact whether the resident' community was asselocal contact agencie entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set fortisection.  §483.21(b)(3) The set	cludes measurable ames to meet a resident's a mental and psychosocial ied in the comprehensive inprehensive care plan must g- are to be furnished to attain ent's highest practicable a psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required a.25 or §483.40 but are not esident's exercise of rights ding the right to refuse a.10(c)(6). ervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)- als for admission and eference and potential for illities must document as desire to return to the assed and any referrals to a sand/or other appropriate ose.  In the comprehensive care in accordance with the in in paragraph (c) of this arvices provided or arranged	F 6	56			
	local contact agencie entities, for this purpo (C) Discharge plans i plan, as appropriate, requirements set fortl section. §483.21(b)(3) The se	s and/or other appropriate ose. In the comprehensive care in accordance with the in paragraph (c) of this					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SU COMPLE	
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NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP COD	<b>_</b> )E	03/13	72023
				11611 ROBIOUS ROAD			
THE LAUF	RELS OF WILLOW CREE	EK .		MIDLOTHIAN, VA 23113			
(V4) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION		(X5)
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F 656	Continued From page	e 18	F 6	56			
		petent and trauma-informed. 「 is not met as evidenced					
	Based on resident in	terview, staff interview, and facility document		Residents #100 no longer the facility. Resident #87 order			
		ined that the facility staff		been updated to include			
		ne comprehensive care plan		non-pharmacological interver	ntion to be		
		s in the survey sample;		offered/attempted prior to bei			
	Residents #100, #88	, #91, #87, and #7.		administered PRN pain medi		/ell	
	T. C. P			as her thyroid replacement th			
	The findings include:			being administered per MD o Resident #7 order for tramad		_	
	The facility policy "C	are Planning" was reviewed.		changed to scheduled. Resid			
		ted, "Every resident in the		Resident #91 no longer resid		٠	
		rson-centered Plan of Care		facility.			
		mented that is consistent					
	with the resident righ			2. An audit will be conducted	on residen	ts	
	comprehensive asse	ssment that includes		who are administered PRN p	ain		
		es and time frames to meet a		medications to ensure orders	include		
		ırsing, and mental and		non-pharmacological interver			
	psychosocial needs	."		offered/attempted. An audit w	<i>i</i> ill also be		
	4 5 5			conducted on residents on			
		), the facility staff failed to		anti-coagulants to ensure ord		,	
	use of an anticoagula	rehensive care plan for the		monitoring of anti-coagulant f effects, to include bleeding a			
	use of all allicoaguis	ant medication.		An audit will also be conducted			
	A review of the clinical	al record revealed an order		residents on thyroid medication			
		quis (1) 5 mg (milligrams)		available.			
		days; and an order dated					
	9/2/23 for Eliquis 5 m			3. Licensed Nurses will be re	-educated l	by	
				October 9, 2023 regarding re	sidents who	0	
	A review of the comp	•		are administered PRN pain m	nedications		
		/25/23 for "(Resident #100)		have orders to include			
		I bleeding/bruising R/T		non-pharmacological interver		_	
		on use. Anticoagulant." This		offered/attempted and docum			
		e intervention, dated 8/25/23		non-pharmacological interver			
		cations as ordered. Observe		attempted, residents on anti-	coagulants		
	for ineffectiveness an	•		orders include monitoring of	المسامع الما		
	abnormal indings to	the physician" and one		anti-coagulant for side effects	,, to include	=	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	(X3) DATE SURVEY COMPLETED	
		495257	B. WING _			C 09/13/2023	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI		00/10/2020	
THE ! ALIE	251 0 05 WILL OW 0D5			11611 ROBIOUS ROAD			
THE LAUF	RELS OF WILLOW CRE	:EK		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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	physician PRN (as-symptoms) of comp blood in urine, black red blood in stools, nausea, vomiting, d lethargy, bruising, b of breath), Loss of a mental status, signit v/s (vital signs), blee or abdominal pain a Further review of the reveal any evidence use of an anticoagu related to risk of ble side effects.  On 9/13/23 at 8:35 a conducted with LPN Nurse). She stated bruising, bleeding, t that monitoring should be completed to the conduction of the complete stated bruising, bleeding, that monitoring should be completed.	Dbserve and report to needed) s/sx (signs and lications: blood tinged/frank at tarry stools, dark or bright sudden severe headaches, iarrhea, muscle joint pain, lurred vision, SOB (shortness appetite, sudden changes in ficant or sudden changes in eding gums, petechiae, back	Fé	bleeding and bruising and re thyroid medications are avail ADON/designee.  4. DON/designee will conduct the MAR of residents with PF anti-coagulants and thyroid residents and thyroid residents with PF anti-coagulants and thyroid residents and thyroid residents are available to the daily clinical meeting, 3 times 2 weeks, weekly times monthly times 2 months to expain medications have ordered documentation on-pharmace intervention are offered/ attended attended anti-coagulant being monitor effects, to include bleeding and every evening shift and Thyromedications are available. A findings will be taken to QAP months to ensure compliance follow the committee recommendations are available.	ct audits of RN pain, medications in imes weekly 2 weeks and nsure PRN s and cological mpted prior to dications; f red for side and bruising oid review of the PI for 3 e and will		
	be documented in the nurse's notes if there are of are not any signs and symptoms and to let the nurse practitioner know if there are any. She stated that if there isn't an order for monitoring, you can ask the doctor and put it in yourself. When asked if the care plan documented to monitor, how do you evidence that you followed it she stated, "Your documentation." She stated that if there is no documentation evidence then the care plan is not being followed.  On 9/13/23 at 8:46 AM, an interview was conducted with LPN #7. She stated that nurses should watch for bruising of any kind, coughing up blood, bleeding profusely from a wound or						

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		495257	B. WING _	NG			C 09/13/2023	
	ROVIDER OR SUPPLIER	K		STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113			10,2020	
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F 656	Continued From page		F	656				
	that evidence of moniprogress notes and a there should be a not occurred so others with on with the resident. evidence of monitoring being followed.  On 9/13/23 at 11:00 A conducted with RN #4 unit manager. She state to be monitoring for side medications. She state documentation of the she cannot say it is be documented it is not occare plan is not being documented.  On 9/13/23 at 11:23 A Staff Member the Ad Director of Nursing, a Clinical Coordinator, of findings. No further in References:  (1) Eliquis - "Apixabate strokes or blood clots fibrillation (a condition irregularly, increasing in the body and possion to caused by heart of a blood clot, usually in embolism (PE; a blood who are having hip resident in the source of the same and	4 (Registered Nurse), the rated that each shift should be effects of anticoagulant ated that there should be monitoring. She stated that eing monitored; if it is not done. She stated that the followed if it is not at AM, ASM #1 (Administrative ministrator, ASM #2 the and ASM #3, the Regional were made aware of the anticomment of the formation was provided.  In is used help prevent in people who have atrial at in which the heart beats at the chance of clots forming bly causing strokes) that is raive disease. Apixaban is deep vein thrombosis (DVT; in the leg) and pulmonary and clot in the lung) in people eplacement or knee						
		Apixaban is also used to display to may be continued to						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495257	B. WING				C <b>13/2023</b>
	ROVIDER OR SUPPLIER	EK		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		10,2020
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F 656	the initial treatment is Information obtained https://medlineplus.go tml	from happening again after completed."	F	656			
	implement the compruse of an anticoagula	ehensive care plan for the					
	dated 8/5/23 for Apix	aban (1) (same as Eliquis) 5 daily for atrial fibrillation.					
	at risk for abnormal b to): medication use. A plan included the inte "Administer medication ineffectiveness and s findings to the physic for "Observe and rep- (as-needed) s/sx (sig complications: blood black tarry stools, dat stools, sudden severe vomiting, diarrhea, m bruising, blurred vision breath), Loss of appe- mental status, signific	d/20/23 for "(Resident #88) is bleeding/bruising R/T (related Anticoagulant." This care ervention, dated 3/20/23 for one as ordered. Observe for ide effects, report abnormal ian" and one dated 3/20/23 for to physician PRN ins and symptoms) of tinged/frank blood in urine, rk or bright red blood in the headaches, nausea, uscle joint pain, lethargy, on, SOB (shortness of titte, sudden changes in cant or sudden changes in ding gums, petechiae, back					
	reveal any evidence of use of an anticoagula	clinical record failed to of nurses monitoring for the ant medication side effects ding and bruising and other					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED		
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	DER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		00/10/2020	
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or co Nu brutha justa be are nu sta yo Will mo sh that the Or co sh up un that pro on ev be Or co un be	nducted with LPN urse). She stated uising, bleeding, that monitoring should at monitoring should at a one-time check documented in the not any signs and urse practitioner know the asked if there is u can ask the documented that if there is u can ask the documented in the conitor, how do you asked if there is no documented with LPN ould watch for brue blood, bleeding plusual places, characteristic of monitorion of the control of the contr	AM, an interview was #6 (Licensed Practical that nurses should "watch for nings like that." She stated ald be throughout the day, not k. She stated that it should be nurse's notes if there are or d symptoms and to let the now if there are any. She n't an order for monitoring, tor and put it in yourself. are plan documented to evidence that you followed it, cumentation." She stated cumentation evidence then	F 6	56			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 656	care plan is not bein documented.	done. She stated that the	F 65	6			
	Staff Member) the Additional Coordinator,	dministrator, ASM #2 the and ASM #3, the Regional were made aware of the information was provided.					
	(1) Eliquis - "Apixaba strokes or blood clot fibrillation (a condition irregularly, increasing in the body and possinot caused by heart also used to prevent a blood clot, usually embolism (PE; a blowho are having hip replacement surgery treat DVT and PE are prevent DVT and PE the initial treatment is Information obtained	<ul> <li>Apixaban is also used to nd may be continued to</li> <li>from happening again after s completed."</li> </ul>					
	implement the comp use of an anticoagul A review of the clinic physician's order dat 5 mg (milligrams) da Wednesday, Thursd						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		495257	B. WING _			C 09/13/2023
	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	•	03/10/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	at risk for abnormal to): medication use. plan included the interplant included the interplant ineffectiveness and straining for "Observe and replant (as-needed) s/sx (signomplications: blood black tarry stools, dastools, sudden sever vomiting, diarrhea, in bruising, blurred visible breath), Loss of apprential status, significations of vision abdominal pain and an experience of an anticoagul related to risk of blees side effects.  On 9/13/23 at 8:35 A conducted with LPN Nurse). She stated bruising, bleeding, the that monitoring should just a one-time check.	prehensive care plan 8/21/23 for "(Resident #91) is bleeding/bruising R/T (related Anticoagulant." This care ervention, dated 8/21/23 for ions as ordered. Observe for iside effects, report abnormal cian" and one dated 8/21/23 port to physician PRN gns and symptoms) of tinged/frank blood in urine, ark or bright red blood in re headaches, nausea, nuscle joint pain, lethargy, on, SOB (shortness of etite, sudden changes in ion to sudden changes in ion ding gums, petechiae, back and nosebleeds."  The clinical record failed to of nurses monitoring for the ant medication side effects eding and bruising and other	Fé	556		
	nurse practitioner kn stated that if there is	d symptoms and to let the ow if there are any. She n't an order for monitoring, tor and put it in yourself.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD   CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 656	When asked if the comonitor, how do you she stated, "Your do that if there is no do the care plan is not  On 9/13/23 at 8:46 conducted with LPN should watch for brup blood, bleeding junusual places, chat that evidence of morprogress notes and there should be a noccurred so others on with the resident evidence of monitor being followed.  On 9/13/23 at 11:00 conducted with RN unit manager. She be monitoring for simedications. She shocumentation of the she cannot say it is documented it is no care plan is not being documented.  On 9/13/23 at 11:23 Staff Member) the ADirector of Nursing, Clinical Coordinator findings. No further	care plan documented to a evidence that you followed it, coumentation." She stated coumentation evidence then being followed.  AM, an interview was War. She stated that nurses using of any kind, coughing profusely from a wound or ange in condition. She stated enitoring is done by charting on a skin note. She stated that ote every day even if nothing will know what has been going and she stated that if there is nothing, then the care plan is not effects of anticoagulant entertheat that there should be the monitoring. She stated that being monitored; if it is not that done. She stated that the nothing monitored; if it is not the done. She stated that the nothing followed if it is not that and ASM #1 (Administrative and ASM #3, the Regional reference and as ware of the reinformation was provided.	F 656		
		arfarin is used to prevent blood or growing larger in your blood			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		495257	B. WING			C
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	l	09/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 656	certain types of irreg prosthetic (replacem valves, and people vattack. Warfarin is all venous thrombosis (vein) and pulmonary lung)." Information obtained https://medlineplus.gtml 4.a. For Resident #failed to implement to care plan for pain materially assessment reference date) of 9/out of 15 on the BIM status), indicating the intact for making dail R87's comprehensive documented, "(R87) to) h/o (history of) m (thoracic) compressidegenerative arthritis back pain, right shocknees	t is prescribed for people with ular heartbeat, people with ent or mechanical) heart who have suffered a heart so used to treat or prevent swelling and blood clot in a embolism (a blood clot in the form gov/druginfo/meds/a682277.h are resident's comprehensive anagement.  MDS (minimum data set), a not with an ARD (assessment 1/23, the resident scored 15 S (brief interview for mental eresident was cognitively ly decisions.  The care plan dated 11/12/22 is at risk for pain r/t (related ultiple falls, chronic T12 on fracture, fibromyalgia, s, hx (history) ankle pain, ald contusion, bilateral Non-Pharmacological	F 6	56		

AND DIAN OF CORRECTION IDENTIFICATION NUMBER			PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113	1 09/13/2023
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 656	Continued From page	e 27	F 65	66	
	physician's order dating (milligrams)- one hours as needed for September 2023 MA record) revealed the as needed ibuprofen 9/4/23, 9/6/23, 9/7/23 of R87's clinical recording 2023 MAR and Septe failed to reveal non-pwere offered or attern On 9/12/23 at 1:49 pconducted with R87, not offer non-pharma pain management.  On 9/12/23 at 3:20 pconducted with LPN LPN #3 stated care pbecause everybody is stated the care plans needed to be done at they can look at the off that prior to the administration pain medication, nursuch as an ice packs repositioning, and do interventions in the non-pharmacological attempted each time medication is administration, but nurses show the same pain, but nurses show the same pain medication is administration, but nurses show the same pain medication is administration, but nurses show the same pain medication is administration, but nurses show the same pain medication is administration, but nurses show the same pain medication is administration, but nurses show the same pain medication is administration, but nurses show the same pain medication is administration, but nurses show the same pain medication is administration, but nurses show the same pain medication is administration, but nurses show the same pain medication is administration, but nurses show the same pain medication is administration.	.m., an interview was who stated the nurses do acological interventions for .m., an interview was (licensed practical nurse) #3. Johans are individualized has different needs. LPN #3 tell you about what is not if anyone has questions, care plans. LPN #3 stated nistration of an as needed sees should offer interventions heating pads or comment the offered urses' notes. LPN #3 stated interventions are not always an as needed pain stered because sometimes interventions cannot be on the location or kind of			

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		495257	B. WING			C
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	<u> </u>	09/13/2023
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F 656	On 9/12/23 at 5:15 p. staff member) #1 (the director of nursin above concern.  4.b. For Resident #87 failed to implement the care plan for thyroid in the care plan for thyroid in the care plan for the care plan	m., ASM (administrative e administrator) and ASM #2 g) were made aware of the 7 (R87), the facility staff he resident's comprehensive replacement therapy.  The care plan dated 11/12/22 is at risk for complications of as: intolerance to cold, weight gain, dry skin, mood in, fatigue & bradycardia (low ter thyroid replacement in the standard process of the standard p	F 6	,		
	administered to R87 A review of the facility	evothyroxine sodium was on 9/10/23 and 9/11/23.  y backup medication supply oxine sodium 75 mcg tablets supply.				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	l	09/13/2023
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F 656	LPN #3 stated care plecause everybody stated the care plans needed to be done at they can look at the nurses should re-ord pharmacy when their LPN #3 stated if a madministration, the mfrom the backup memedication is not awanurses should call the medication to be ser On 9/13/23 at 3:07 pmember) #1 (the addirector of nursing) wabove concern.  Reference: (1) "Levothyroxine is (condition where the produce enough thy information was obtain https://medlineplus.gtml.  5. For Resident #7 (implement the compuse of non-pharmace the administration of medication, Tramado R7 was admitted with not limited to osteoa.	(licensed practical nurse) #3. clans are individualized has different needs. LPN #3 is tell you about what is and if anyone has questions, care plans. LPN #3 stated her medications from the eare five or six pills left. edication is not available for nedication should be pulled dication supply, and if the ailable in the supply, then the her epharmacy and ask for the hast STAT (immediately).  I.M. ASM (administrative staff ministrator) and ASM #2 (the were made aware of the her was a ware of the her was a ware of the horizontal pland does not roid hormone)." This ained from the website: hov/druginfo/meds/a682461.h	F 6	56		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	1 00/10/2020
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F 656	for mental status), indintact for making dail Management" coded at a pain level of six of worse pain.  The physician order of "Tramadol HCI (hydro (milligrams). Give 1 8 (eight) hours as ne Order Date: 10/25/20 The eMAR (electronic record) for R7 dated the physician's order eMAR revealed that Tramadol 50mgs bet 08/31/2023 with no enon-pharmacological attempted and documented the physician's pain and the type The eMAR (electronic record) for R7 dated documented the physician and the type above. The eMAR redoses of Tramadol 50 and 09/11/2023 with non-pharmacological attempted prior to the for R7.  The nursing progress	on the BIMS (brief interview dicating R7 was cognitively by decisions. Section J "Pain R7 as having frequent pain but of ten, with ten being the for R7 documented in part, pochloride) Tablet 50 MG (one) tablet by mouth every eded for Pain level 6-10. 122."  The medication administration august 2023 documented as as stated above. The R7 received 67 doses of ween 08/01/2023 and vidence of interventions being mentation of the location of the of pain.  The medication administration september 2023 sician's orders as stated evealed that R7 received 20 mgs between 09/01/2023 no evidence of interventions being administration of Tramadol and interventions being administration of Tramadol and interventions being administration of Tramadol and 19/11/2023 failed to evidence on-pharmacological tempted prior to the	F 650		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	EEK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	03/13/2023
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F 656	documented in part episodes r/t (related (osteoarthritis) with to) RA (rheumatoid radiculopathy, h/o (I (diabetes mellitus) validated: 02/22/2022 documented in part Interventions. 1) Ma Meditation/Relaxatic pack. 5) Diversional 7) Rest. 8) Social in Initiated: 02/22/2022 On 09/12/23 at apprinterview was conducted with Episonal role facility staff atterintervention prior to stated no.  On 9/12/23 at 3:20 conducted with LPN She stated in regard interventions, LPN from interventions such a or repositioning, and interventions in the non-pharmacological attempted each time medication is admin non-pharmacological attempted depending pain, but nurses sho non-pharmacological attempted.  On 09/12/2023 at a graph of the part o	e care plan dated 02/22/2022 "Need. (R7) actual pain Ito) severe L (left) knee OA debility, Chronic pain d/t (due arthritis), lumbar history of) migraines, DM vith neuropathy. Date 2." Under "Interventions" it "Offer Non-Pharmacological issage. 2) on. 3) Positioning. 4) Ice/cold activity. 6) Guided Imagery. teraction. 9)Other. Date 2."  roximately 9:21 a.m., an acted with R7. When asked if mpt non-pharmacological administrating Tramadol, R7  o.m., an interview was I (licensed practical nurse) #3. It to non-pharmacological is a stated nurses should offer as an ice packs, heating pads d document the offered nurses' notes. LPN #3 stated al interventions are not always e an as needed pain histered because sometimes al interventions cannot be ag on the location or kind of	F 656		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	ĸ		STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113	09/13/2023
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F 658 SS=D	clinical coordinator, wabove findings.  No further information References: (1) Tramadol is used moderately severe parabeta in the weath type://medlineplus.goml.  (2) The most common pain, swelling, and rest can occur in any join hands, knees, hips or was obtained from the https://medlineplus.goml.  (2) The most common pain, swelling, and rest can occur in any join hands, knees, hips or was obtained from the https://medlineplus.gomlines.goml	to relieve moderate to in. This information was posite: py/druginfo/meds/a695011.ht in form of arthritis. It causes duced motion in your joints. In the but usually it affects your spine. This information we website: py/osteoarthritis.html. Pet Professional Standards of or arranged by the facility, in prehensive care plan, standards of quality. It is not met as evidenced standards of practice for	F 65	56	
	Residents #87, #55 a The findings include: 1. For Resident #87 (	nd #225. R87), the facility staff failed		2. An audit will be conducted of resider who have orders for nothing by mouth ensure medications are not ordered to	to

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	•	3/10/2020	
				11611 ROBIOUS ROAD			
THE LAUF	RELS OF WILLOW CRE	EK		MIDLOTHIAN, VA 23113			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (  (EACH CORRECTIVE A  CROSS-REFERENCED TO  DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	sodium (1) 75 mcg (order on 9/10/23 and A review of R87's cliphysician's order da sodium 75 mcg- one morning for hypothy September 2023 Marecord) revealed the levothyroxine sodium the MAR documented Nurse Notes." Nurse 9/11/23 documented available in the med nurses' notes and the failed to reveal documential sodium was administ 9/11/23.  A review of the facility	edication levothyroxine imicrograms) per physician's d 9/11/23.  Inical record revealed a ted 9/6/23 for levothyroxine e tablet by mouth in the roidism. A review of R87's AR (medication administration e same physician's order for m. On 9/10/23 and 9/11/23, ed the code, "5=Hold/See es' notes dated 9/10/23 and d the medication was not ication cart. Further review of the September 2023 MAR the stered to R87 on 9/10/23 and the ty backup medication supply roxine sodium 75 mcg tablets	F 6	given by mouth, levothyre medications are available who have had outside ap last 30 days to ensure ne medications have been of the MD/NP.  3. Licensed Nurses will be October 9, 2023 regardin have orders for nothing be ensure medications are regiven by mouth, levothyre medications are available who have had outside ap ensure new orders for me been communicated to the ADON/designee.  4. DON/designee will corresidents who have ordered to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to be given by medications are available who have had outside approached to b	e and residents oppointments in the ew orders for communicated to  the re-educated by ng residents who by mouth to not ordered to be oxine sodium e and residents oppointments to edications have the MD/NP by the  anduct audits of the for nothing by tions are not nouth, thyroid e and residents		
	conducted with LPN LPN #3 stated nurse medications from the five or six pills left. It is not available for a should be pulled from supply, and if the medication the supply, then the pharmacy and ask for STAT (immediately).  On 9/12/23 at 5:15 processed to staff member) #1 (the supply is staff member)	e pharmacy when there are LPN #3 stated if a medication dministration, the medication m the backup medication edication is not available in nurses should call the or the medication to be sent		ensure new orders for me been communicated to the daily clinical meeting, 3 to times 2 weeks, weekly times 2 months. Findings will be taken to 0 months to ensure complications of the committee recommunity of the committee recommittee.	edications have the MD/NP in the imes weekly mes 2 weeks and A review of the QAPI for 3 ance and will		

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	ROVIDER OR SUPPLIER	EEK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		37 107 2020
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F 658	Continued From pa	ge 34	F 658	3		
	above concern.					
		umented, "Medications are ordance with written orders of				
	(condition where the produce enough thy information was obt	s used to treat hypothyroidism e thyroid gland does not roid hormone)." This ained from the website: gov/druginfo/meds/a682461.h				
	to accurately transc	is (R55), the facility staff failed ribe a physician's order to lent's potassium via PEG oscopic gastrostomy) tube n.				
	physician's order da Mouth diet, Nothing Mouth consistency. clinical record revea 8/18/23 for potassiu	linical record revealed a lated 8/17/23 for, "Nothing by by Mouth texture, Nothing by "Further review of R55's laled a physician's order dated am chloride liquid 20 milliliters- 20 milliequivalents as a day.				
	conducted with LPN LPN #3 stated if a r physician's order fo medications should the order should do that when the nurse system, they get us	p.m., an interview was I (licensed practical nurse) #3. esident with a peg tube has a r nothing by mouth, then be administered via peg, and cument that. LPN #3 stated es put orders into the computer ed to entering the route as "by ne may have unintentionally				

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(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	( (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
entered the wrong router. Interviews were conditioned for R55. The nurses resident's medication on 9/12/23 at 5:15 p staff member) #1 (th (the director of nursidabove concern.  The facility policy title receiving the order in order is complete an route"  3. For Resident #22 failed to obtain a phyby the consulting phyby	ducted with nurses who cared a stated they administer the as via peg.  I.m., ASM (administrative e administrator) and ASM #2 ang) were made aware of the  ed, "The licensed nurse aust verify to ensure the dit includes: Accurate  5 (R225), the facility staff visician's order as prescribed visician for the medication, differ urinary retention.  with diagnoses that included to benign prostatic  note for R225 documented in office visit: General. The anied by his son" Under any" it documented in part, mg (milligram) capsule (one) capsule by mouth as 10 a.m.) daily."  from the urologist for R225 3:58 p.m. documented in 5 mg capsule. Dispense 30 ke (one) capsule by mouth as	F	358			
	ROVIDER OR SUPPLIER  SUMMARY S' (EACH DEFICIENC REGULATORY OR  Continued From page entered the wrong routered the wrong router is complete an route"  3. For Resident #22 failed to obtain a phyby the consulting phy Dutasteride (1), used R225 was admitted but were not limited but	A95257  ROVIDER OR SUPPLIER  RELS OF WILLOW CREEK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 35 entered the wrong route for R55's potassium.  Interviews were conducted with nurses who cared for R55. The nurses stated they administer the resident's medications via peg.  On 9/12/23 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "The licensed nurse receiving the order must verify to ensure the order is complete and it includes: Accurate route"  3. For Resident #225 (R225), the facility staff failed to obtain a physician's order as prescribed by the consulting physician for the medication, Dutasteride (1), used for urinary retention.  R225 was admitted with diagnoses that included but were not limited to benign prostatic	RELS OF WILLOW CREEK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 35 entered the wrong route for R55's potassium.  Interviews were conducted with nurses who cared for R55. The nurses stated they administer the resident's medications via peg.  On 9/12/23 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "The licensed nurse receiving the order must verify to ensure the order is complete and it includes: Accurate route"  3. For Resident #225 (R225), the facility staff failed to obtain a physician's order as prescribed by the consulting physician for the medication, Dutasteride (1), used for urinary retention.  R225 was admitted with diagnoses that included but were not limited to benign prostatic hyperplasia (2).  A urology office visit note for R225 documented in part, "11/25/2022 - Office visit: General. The patient was accompanied by his son" Under "Prescription(s) Today" it documented in part, "Dutasteride (2) 0.5 mg (milligram) capsule (dutasteride) Tale 1 (one) capsule by mouth as directed at 9 am (9:00 a.m.) daily."  The prescription slip from the urologist for R225 dated 11/25/2022 at 3:58 p.m. documented in part, "Dutasteride 0.5 mg capsule. Dispense 30 (thirty) capsules. Take (one) capsule by mouth as directed at 9 AM daily."	ROUDER OR SUPPLIER RELS OF WILLOW CREEK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 35 entered the wrong route for R55's potassium.  Interviews were conducted with nurses who cared for R55. The nurses stated they administrative resident's medications via peg.  On 9/12/23 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "The licensed nurse receiving the order must verify to ensure the order is complete and it includes: Accurate route"  3. For Resident #225 (R225), the facility staff failed to obtain a physician's order as prescribed by the consulting physician for the medication, Dutasteride (1), used for urinary retention.  R225 was admitted with diagnoses that included but were not limited to benign prostatic hyperplasia (2).  A urology office visit note for R225 documented in part, "11/25/2022 - Office visit: General. The patient was accompanied by his son" Under "Prescription(s) Today" it documented in part, "Dutasteride (2) 0.5 mg (milligram) capsule (dutasteride) Tale (aps) capsule by mouth as directed at 9 am (9:00 a.m.) daily."  The prescription slip from the urologist for R225 dated 11/25/2022 at 3:58 p.m. documented in part, "Dutasteride 0.5 mg capsule. Dispense 30 (thirty) capsules. Take (one) capsule by mouth as directed at 9 AM daily."	A BUILDING B. WING  A STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113  SUMMARY STATEMENT OF DEPICIENCIES  (EACH DEPICIENCY MUST RE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 35  entered the wrong route for R55's potassium.  Interviews were conducted with nurses who cared for R55. The nurses stated they administer the resident's medications via peg.  On 9/12/23 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "The licensed nurse receiving the order must verify to ensure the order is complete and it includes: Accurate route"  3. For Resident #225 (R225), the facility staff failed to obtain a physician's order as prescribed by the consulting physician for the medication, Dutasteride (1), used for urinary retention.  R225 was admitted with diagnoses that included but were not limited to benign prostatic hyperplasia (2).  A urology office visit note for R225 documented in part, "11/25/2022 - Office visit: General. The patient was accompanied by his son" Under "Prescription," lodge," long (milligram) capsule (dutasteride) Tale 1 (one) capsule by mouth as directed at 9 am (9:00 a.m.) daily."  The prescription slip from the urologist for R225 dated 11/25/2022 a 1.58 p.m. documented in part, "Dutasteride (0.5 mg capsule) by sosule. Dispense 30 (thirty) capsules. Take (one) capsule by mouth as directed at 9 AM daily."	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY  COMPLETED
		495257	B. WING			C <b>09/13/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	IP CODE	09/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TO THE APPROPRIA	
F 658	documented in part, MG. Give 1 capsule benign prostatic hypo 11/28/2022."  The eMAR (electroni record) for R225 date documented the phy above, however the wasn't administered.  The nurse practitione 11/28/2022 at 1:53 p "A/P (assessment/pla 11/28"  On 09/12/2023 at ap interview was condupractical nurse) #8. procedure when a represcription for a me outside of the facility should put order in ophysician or NP if the them to let them kno prescription, put the and call the pharmac available in the facility recalled R225 and w back to the facility from 11/25/2022 she state R225 and his son cate appointment between with a prescription for further stated she did on 09/13/2023 at ap interview was conducted.	"Dutasteride Capsule 0.5 by mouth at bedtime for explasia. Order Date:  c medication administration and November 2022 sician's order as stated first dose of dutasteride until 11/28/2022.  er's (NP) note for R225 dated .m., documented in part, an) Dutasteride added  proximately 3:43 p.m., an cted with LPN (licensed When asked to describe the sident brings in a dication from a provider she stated that the nurse computer, talk to the ey are in the building or call we the resident has a new script in the doctors book by if the medication is not ety. When asked if they hen R225's son brought him on a urology appointment on ed yes. LPN #8 stated that	F	558		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED			
		495257	B. WING _			C <b>09/13/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	ı	09/13/2023
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 658	asked to describe the when a resident receprescription from a pshe stated that the stay the resident recession further stated the facility the nurse wow. When asked if she refor Dutasteride she stated that that staff and she had them cathe order on Monday.  On 09/13/2023 at apinterview was condustaff member) #2, directly asked about R225 newhen it was ordered stated that the reside the script was handed the pharmacy but did provider. She furthenotified on the follow R225 received his firm	e procedure she follows eives a script for a rovider outside of the facility, taff gives the scrip to her the eives it or the next morning. at if she were not in the ald call the on-call provider. ecalled R225 and the order stated that she did and further could not locate the order all the pharmacy and verify (11/28/2023).  Proximately 11:00 a.m., an octed with ASM (administrative rector of nursing. When not receiving Dutasteride by the urologist ASM #2 ent arrived around 8:00 p.m., d to the nurse and faxed it to d not notify the on-call r stated that the NP was ing Monday, 11/28/2022, and st dose that day. When delay in R225 receiving his	F 6	58		
	11/29/2022 documer concern about? Had Friday and brought pback. Handed to a morning and medica Concerned this is a sproblem occur? Frid Response: NP reachnew script and order Taken: Writer spoke	ce form for R225 dated ated in part, "What is your of urology appt (appointment) apperwork and prescription at the control of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(:	(X3) DATE SURVEY COMPLETED	
		495257	B. WING _			C <b>09/13/2023</b>	
	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CO 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	DDE	03/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  ID  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  TAG  CROSS-REFERENCED TO THE APPROPRIAT  DEFICIENCY)		(X5) COMPLETION DATE			
F 676	scan pile. She stated PCC (point click care Writer informed nurse placed in the MD (me put in PCC."  On 09/13/2023 at apple (administrative staff rand ASM #2, director aware of the above file. No further information.  References: (1) Used alone or with (tamsulosin [Flomax] hyperplasia (BPH; ergland). May reduce the acute urinary retention obtained from the weak https://medlineplus.gtml.  (2) An enlarged prostobtained from the weak https://www.nlm.nih.gstatebph.html.  (3) A class of medical management and tree hyperplasia (BPH). To obtained from the weak https://www.ncbi.nlm.	darmacy and placed in the dishe did not put the order in expectation bealth record. The expectation of the edical doctor and order sproximately 3:00 p.m., ASM member) #1, administrator, for of nursing, were made indings.  In was provided prior to exit.  The hanother medication of the prostate of the prostate of developing on. This information was ebsite:  This information was ebsite:	F 6			10/16/23	
	CFR(s): 483.24(a)(1)	,				15/15/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495257	B. WING			C 9/13/2023	
	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CO 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		0/10/2020	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 676	resident's needs and provide the necessar ensure that a resider daily living do not din of the individual's clir that such diminution includes the facility e §483.24(a)(1) A resident treatment and service or her ability to carry living, including those of this section §483.24(b) Activities The facility must provaccordance with para activities of daily living \$483.24(b)(1) Hygier grooming, and oral ce §483.24(b)(2) Mobilitincluding walking, §483.24(b)(3) Eliminal §483.24(b)(4) Dining snacks, §483.24(b)(5) Comment (i) Speech, (ii) Language, (iii) Other functional of This REQUIREMENT by:	the comprehensive dent and consistent with the choices, the facility must by care and services to nt's abilities in activities of ninish unless circumstances nical condition demonstrate was unavoidable. This insuring that:  dent is given the appropriate es to maintain or improve his out the activities of daily especified in paragraph (b)  of daily living.  vide care and services in agraph (a) for the following especified in paragraph, are,  cy-transfer and ambulation,  ation-toileting,  -eating, including meals and	F 679	1. Resident #24 has confirm	ned her ADI		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495257	B. WING _				C 1 <b>13/2023</b>
	ROVIDER OR SUPPLIER	K		11	TREET ADDRESS, CITY, STATE, ZIP CODE 1611 ROBIOUS ROAD 1IDLOTHIAN, VA 23113	1 00/	10/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676	interview, clinical recodetermined that the factorial factorial residents, Resident # The findings include: For Resident #24 (R2 provide timely inconting R24 was admitted to that included but wer wasting and abnormation on the most recent factorial reference date) of 06 scored 10 out of 15 cored for mental status), incomplete interview.	ord review, it was acility staff failed to provide y living) for one of 37 24.	F	576	needs are met to include incontinence care met by staff.  2. Incontinent residents will be audited ensure that their ADL needs are met by staff in a timely manner, including incontinence care by care rounds.  3. Nursing staff will be re-educated by October 9, 2023 to ensure residents AI needs are met by staff in a timely mannincluding incontinence care by the ADON/designee.  4. Department Managers/designee will conduct audits by way of care rounds of incontinent residents 3 times weekly tir 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure residents ADL are met by staff in a times	OL ner, of mes	
	On 09/11/23 at 12:35 revealed that R24 ac incontinence care.  On 09/11/23 at 12:45 revealed CNA (certificentered R24's room, the room with R24's I On 09/11/2023 at 1:0 revealed LPN (licensentered R24's room a care.  On 09/12/23 at approximately contact the contact of the cont	ed nursing assistant) #2 turned off the call and left			manner, including incontinence care. A review of the findings will be taken to QAPI for 3 months to ensure compliant and will follow the committee recommendations.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
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		495257	B. WING _			09/13/2023	
	ROVIDER OR SUPPLIER	REEK		STREET ADDRESS, CITY, STATE, ZIP CODI 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 676	entering R24's root the day before, sh R24's meal tray ar clean her up. CN/that when she finis she would come becare. When asked up the meal trays, 1:00 p.m. but could when asked how incontinence care she stated that it is the resident is not asked if R24's was Monday 0-9/11/20 informed of the ab waited approximatincontinence care informing CNA #2, have notified the nincontinence care.  On 09/12/23 at apinterview was conceptated incontinence care after informing that the resident sincontinence care.  On 09/12/23 at apinterview was conceptated incontinence care.	#2. When asked about her m at approximately 12:45 p.m., e stated that she picked up and that R24 asked if she would A #2 stated that she told R24 shed picking up the meal trays ack and provide incontinence d what time she finished picking CNA #2 stated that it was after d not recall the exact time. It is song a resident should wait for after informing a staff member, should be done right away so sitting in a soiled brief. When so notheir assignment for 23, she stated yes. When ove observations and that R24 ely 25 minutes to receive after activating her call bell and CNA #2 stated that she could urse that R24 required  proximately 1:33 p.m., an ducted with LPN (licensed et al., unit manager. When asked the should wait for incontinence g a staff member, she stated hould only have to wait within When informed of the above #2 stated that the CNA should know R24 required	F	576			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495257	B. WING		C 09/13/2023
	ROVIDER OR SUPPLIER	EK	1 03/10/2020		
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F 686 SS=D	stated that she provision that the resident was that she was not away waiting for incontineing just walked onto the The facility's policy documented in part, necessary assistance and personal/oral hy to documented in part provided timely acconneeds."  On 09/12/2023 at approvided timely acconneeds."  On further information treatment/Svcs to PCFR(s): 483.25(b)(1) Pression and the same pressure on the comprovided timely acconnected to the same pressure ulcers and ulcers unless the individual demonstrates that the (ii) A resident with pricessary treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment with professional standary pressure ulcers and ulcers unless the individual treatment wi	dec care to R24, LPN #4 ded incontinence care, and s wet. LPN #4 further stated are that R24 had been ince care because she had unit.  Routine Resident Care" it "Residents receive the se to maintain good grooming rgiene." Under "Guidelines" int, "8. Incontinence care is ording to each resident's  proximately 5:07 p.m., ASM member) #1, administrator, nursing and ASM #3, regional were made aware of the  on was provided prior to exit. Prevent/Heal Pressure Ulcer (i)(i)(ii)  grity ure ulcers. ehensive assessment of a must ensure that- es care, consistent with do of practice, to prevent does not develop pressure lividual's clinical condition ney were unavoidable; and ressure ulcers receives and services, consistent undards of practice, to event infection and prevent	F 68		10/16/23

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495257	B. WING	_		l '	C 42/2022
NAME OF PE	ROVIDER OR SUPPLIER	100201	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	13/2023
TVAINE OF T	TO VIDER OR GOL LEEK				1611 ROBIOUS ROAD		
THE LAUF	RELS OF WILLOW CREE	:K			IIDLOTHIAN, VA 23113		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	by: Based on staff intervand facility document that the facility staff faservices for the treatrone of 37 residents in Resident #205.  The findings include: The facility policy, "SI reviewed. This policy admission/re-admissi evaluated for skin into baseline total body sk the electronic medica Guests/residents admimpairment will have: implemented to promorder for treatment, a measurements and coumented"  The facility staff failed measurements, and sthe initial admission of wound care physician approximately seven failed to evidence that two days after admission MDS (Resident #205 was a 8/17/22 and discharg the admission MDS (	iew, clinical record review review, it was determined ailed to provide care and ment of pressure injuries for the survey sample;  kin Management" was a documented, "Upon all guests/residents are regrity by completing a com	F	386	1. Resident #205 no longer resides in facility.  2. Residents with pressure ulcers will be audited to ensure documentation of wounds is complete including descriptions, measurements, staging a treatment orders are initiated.  3. Licensed nurses will be re-educated October 9, 2023 on ensuring pressure ulcer documentation is complete included descriptions, measurements, staging a treatment orders are initiated by the ADON/designee.  4. DON/designee will conduct audits of pressure ulcer documentation 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure documentation is complete including descriptions, measurements staging and treatment orders are initiated. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	e nd by ing nd	
	Review of the clinical	record failed to reveal any					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495257	B. WING			C 99/13/2023	
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COL 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		13/13/2023	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 686	as it was not docume clinical record failed to treatment was initiated the first two days of an an area orders, in chronologic and an area an	e MDS staging came from Inted anywhere. Also, the oreveal evidence that dupon admission and for dmission.  If record revealed the administration of those cal order of the order date:  Wound consult as-needed. In the stage of the resident on 8/22/22, 9/21/22.  In the resident on 8/22/22, 9/21/22.  In the resident on 8/22/24, 9/21/25.  In the resident on 8/22/26, 9/21/26.  In the resident on 8/22/27, 9/21/26.  In the resident on 8/22/26, 9/21/26.  In the resident on 8/22/26, 9/21/26.  In the resident on 8/22/27, 9/21/26.  In the resident on 8/22/27, 9/21/26.  In the resident on 8/22/27, 9/21/26.  In the resident on 8/22/22, 9/21/26.  In the resident of the TAR and the resident of the resident of the resident of the revealed this order was administered as a substant of the TAR for the resident of the TAR for the TAR	F 68				

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495257	B. WING			C 9/13/2023	
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	•	9/13/2023	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	this order was discon administered as order An order 9/8/22 barrie every shift. A review order was discontinuated completed as ordered opportunities it was no evidence whether documented or was revidence that this reson the resident.  Further review of the following notes and a chronological order:  The admission nurse documented the resident there was a "rig cmopen area on le cm wide"  The nurse practitione initial assessment of address the wounds.  A skin assessment dadocumented "Num 0. Comments: open  The nurse practitione PM documented, "s woundswound care	September 2022 revealed tinued on 9/8/22 and was red.  er cream to bilateral buttocks of the TAR revealed this ed upon discharge and was dexcept one time out of 42 of documented. There was it was done and not not done. There was no sulted in any negative impact clinical record revealed the ssessments, in  's note dated 8/17/22 dent arrived at 8:15 PM and ght buttock open red area 1 fit buttock approximately 1  er note dated 8/18/22, the this resident, did not  ated 8/19/22 at 4:02 PM ber of new skin conditions: area to buttocks"  er note dated 8/20/22 at 4:01 skin:Bilateral buttock e order updated"	F 68	36			

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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F 686	Continued From page	<del>2</del> 46	F 6	686				
	12:23 PM documente	r note dated 8/24/22 at d, "seen in bed, wounds MD, b/l (bilateral) buttocks ."						
	buttockWound Size 0.1Stage 3 pressu	e 3 pressure wound right (L x W x D) 2.9 x 1.6 x						
	first with complete medescription of the work approximately seven was no evidence of mone centimeter docur was not a complete medescription other than admission, and any sto this note. In addition that any wound treat admission when the work until approximately 16 the first application of documented until 8/19 TAR.	days after admission. There neasurements other than the nented on admission which neasurement, any neasurement, any ned and "open area" on taging of these wounds prior on, there was no evidence nent was initiated upon wound was initially identified, of hours after admission, and this treatment was not 2/22, per the August 2022						
	buttockWound Size 0.1Stage 3 pressu	e 3 pressure wound right (L x W x D) 1.4 x 0.9 x						
	The next wound phys 9/14/22. This note do 9/14/22, both wounds							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		495257	B. WING			C 9/13/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		9/13/2023
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 686	Nurse). She stated the admitted with wounds assessed, cleaned and staff should obtain we the orders, and the numanager and the document has and where they adescription of the worders are wound, they it, and that treatment obtained immediately.  On 9/13/23 at 9:52 A conducted with ASM Member), the nurse puther wounds were hear concerns regarding to the wounds were hear concerns. He did not unable to speak to the his initial evaluation one week after admissions would be stated with RN # MDS nurse. She stated that she in of the resident's would stated the stated that she in of the resident's would stated the stated that she in of the resident's would stated the stated that she in of the resident's would stated the stated that she in the resident's would stated the	M, an interview was #6 (Licensed Practical hat when a resident is s, the wounds should be nd dressed. She stated that bund orders for it, implement ext morning the unit ctor go in and do their ated that wounds should be ed as to what the resident are located, a detailed und and treatment should be She stated that when staff by are going to have to dress orders should have been  M, an interview was #4 (Administrative Staff bractitioner. She stated that aled. She did not have any he wound treatment.  AM, an interview was #5, the wound care t recall the resident and was e pressure wounds prior to of the wound, approximately	F 68	36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	()	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NO		С	
		495257	B. WING			09/13/2023	
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE,	ZIP CODE		
THE LAU	RELS OF WILLOW CR	EEK		MIDLOTHIAN, VA 23113			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 686	documented in the that she does not hobservation but that observations and i ARD (Assessment The ARD for the ac same day as the width She stated that he would not have been two following ad closer to the ARD of the ARD o	clinical record. She stated know what day she made the at typically, she does her interviews on or close to the Reference Date) of the MDS. It is dission MDS was 8/24/22, the round care physician's first visit. It is observations and interviews en done the day of or in the day mission; it would have been date.  O AM, an interview was at #4, the unit manager. She at skin check and then two at hours should be done-at the following shifts for two more that documentation should be cossible. She stated that the for physician should then go in the stage wounds are able to stage wounds are comfortable. She stated that wounds in the first 24 hours. We would do a description and inion on what the stage is. She mould have been obtained on omething started. She stated that wound care was provided and staging. She stated that been better documentation of fund care initiated and a note as provided even if there	F	586			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495257	B. WING		C 09/13/2023
	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113	007107202
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 686	Clinical Coordinator, findings. No further i	e 49 and ASM #3, the Regional were made aware of the nformation was provided. stomy Care and Suctioning	F 68		10/16/23
SS=D	S 483.25(i) Respirator tracheostomy care at The facility must ensineeds respiratory care and tracheal surcare, consistent with practice, the comprescare plan, the reside and 483.65 of this surthis REQUIREMENT by:  Based on observation record review, it was failed to provide respisanitary manner for curvey sample, Resident #21 (Restore a CPAP (continument) (1) mask in R21 was admitted to that included but were obstructive sleep aproving the most recent of (minimum data set), an ARD (assessmen 07/14/2021, R21 score a CP/14/2021, R	ary care, including and tracheal suctioning. Unre that a resident who re, including tracheostomy actioning, is provided such professional standards of mensive person-centered ants' goals and preferences, bpart.  To is not met as evidenced on, staff interview, and clinical determined that facility staff irratory care and services in a one of 37 residents in the dents #21.  21), the facility staff failed to uous positive airway in a sanitary manner.  To the facility with diagnoses in a sanitary manner.		1. Resident #21 C-pap mask was immediately bagged in a sanitary mar  2. Residents with C-pap machines wil audited to ensure masks are bagged sanitary manner.  3. Nursing staff and managers will be re-educated by October 9, 2023 on ensuring C-pap masks are bagged in sanitary manner by the ADON/design  4. Managers/designee will conduct au of residents who have C-pap machine times weekly times 2 weeks, weekly tild 2 weeks and monthly times 2 months ensure masks are bagged in a sanitar manner. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the commit recommendations.	a ee. dits es 3 imes to y ee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,			(X3) DATE COMP	SURVEY LETED
		495257	B. WING				C 13/2023
	ROVIDER OR SUPPLIER	I EK		1	TREET ADDRESS, CITY, STATE, ZIP CODE 1611 ROBIOUS ROAD IIDLOTHIAN, VA 23113	1 03/	13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	Section O "Special Top Programs" coded R2 resident.  On 09/11/23 at approphered observation of R21's mask laying on the or observation of R21's mask layin	tor making daily decisions. reatments, Procedures and 1 for "CPAP" while a siximately 12:32 p.m., an room revealed a CPAP ver-the-bed table uncovered. Eximately 4:30 p.m., an room revealed a CPAP ver-the-bed table uncovered. Eximately 9:00 a.m., an room revealed a CPAP ver-the-bed table uncovered. Eximately 9:00 a.m., an room revealed a CPAP ver-the-bed table uncovered. For R21 documented in when laying down as ribed settings. every shift for 06/15/2021."  Eximately 9:01 a.m., an exted with R#38. When asked the CPAP mask she stated not provided a bag to store it able to reach the mask and lace the mask in a bag.  Exproximately 11:00 a.m., an exted with ASM (administrative externor of nursing. After a observations she was the CPAP mask should be being used. ASM #2 stated	F	695			

		(X3) DATE SURVEY COMPLETED			
		495257	B. WING		C 09/13/2023
	ROVIDER OR SUPPLIER	K		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	1 00/10/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 695		e 51 ursing and ASM #3, regional vere made aware of the	F 69	5	
	above findings.  No further information	n was provided prior to exit.			
	uses a machine to puthe airway of the lung windpipe open during delivered by CPAP (opressure) prevents ethat block the breathisleep apnea and othe information was obtain	essure (PAP) treatment amp air under pressure into us. This helps keep the place seep. The forced air continuous positive airway poisodes of airway collapseing in people with obstructive er breathing problems. This ined from the website:			
	causes your breathin Breathing pauses car minutes. They may o hour. This informatio	common disorder that g to stop or get very shallow. I last from a few seconds to ccur 30 times or more an n was obtained from the neplus.gov/sleepapnea.html.	F 69	7	10/16/23
	provided to residents consistent with profes the comprehensive p and the residents' go. This REQUIREMENT by:  2. For R7 the facility	ure that pain management is who require such services, ssional standards of practice, erson-centered care plan,		1 Resident #87 and Resident #7 non-pharmacological intervention are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495257	B. WING			1	C / <b>13/2023</b>	
	ROVIDER OR SUPPLIER	к		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		1 00/	10/2020	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE	
F 697	on the most recent M quarterly assessment reference date) of 07 scored 15 out of 15 of for mental status), indintact for making daily Management" coded at a pain level of six of worse pain.  R7's comprehensive documented in part, "episodes r/t (related the total (osteoarthritis) with dotal total (osteoarthritis) with dotal total (osteoarthritis) with dotal (diabetes mellitus) will initiated: 02/22/2022. documented in part, "Interventions. 1) Mass Meditation/Relaxation pack. 5) Diversional at 7) Rest. 8) Social interventions. 1 (hydround) (milligrams). Give 1 (leight) hours as need order Date: 10/25/20	n (as needed) pain I (1).  I diagnosis that included but thritis (2) of the knee.  IDS (minimum data set), a with an ARD (assessment /20/2023, the resident n the BIMS (brief interview dicating R7 was cognitively y decisions. Section J "Pain R7 as having frequent pain out of ten, with ten being the care plan dated 02/22/2022 Need. (R7) actual pain o) severe L (left) knee OA ebility, Chronic pain d/t (due thritis), lumbar story of) migraines, DM th neuropathy. Date "Under "Interventions" it 'Offer Non-Pharmacological sage. 2)  n. 3) Positioning. 4) Ice/cold activity. 6) Guided Imagery. Eraction. 9)Other. Date "  or R7 documented in part, ochloride) Tablet 50 MG (one) tablet by mouth every eded for Pain level 6-10.	F 69	administered PRN pain medical 2 An audit will be conducted or who are administered PRN pair medications to ensure orders in non-pharmacological intervent offered/attempted.  3 Licensed Nurses will be re-expected offering/attempting non-pharmacological intervention prior to administer pain medications by the ADON 4 DON/designee will conduct a MAR of residents with PRN pair medications in the daily clinical times weekly times 2 weeks, where 2 weeks and monthly times 2 rensure non-pharmacological in are offered/attempted prior to administering PRN pain medical documented. A review of the file taken to QAPI for 3 months compliance and will follow the recommendations.	n resider in include cion are ducated acologicating PRN l/designer audits of ain months to the revention arindings we to ensure indings we to ensure include a to ensure a to ensu	by eal leee. the g, 3 mes o on nd vill		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, , ,	(X3) DATE SURVEY COMPLETED	
		495257	B. WING _			C 9/13/2023	
	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CO 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		3/13/2023	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 697	Continued From page	e 53	F 6	97			
	eMAR revealed that I Tramadol 50 mgs be 08/31/2023, with no e non-pharmacological	s as stated above. The R7 received 67 doses of tween 08/01/2023 and evidence of interventions attempted and the location and type of R7's					
	record) for R7 dated documented the physiabove. The eMAR redoses of Tramadol 50 and 09/11/2023 with non-pharmacological	sician's orders as stated evealed that R7 received 20 0 mgs between 09/01/2023					
	documentation of noi interventions prior to	09/11/2023 failed to evidence n-pharmacological					
	interview was conduct the facility staff attern intervention, ask for t	eximately 9:21 a.m., an exted with R7. When asked if apt non-pharmacological the location of pain or type of trating Tramadol, R7 stated					
	LPN #3 stated that point needed pain medicate the resident where the the pain is throbbing rate the pain, ask the	.m., an interview was (licensed practical nurse) #3. rior to administering an as ion, the nurses should ask the pain is, ask the resident if or sharp, ask the resident to the resident if the pain is new, al indicators of pain, and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X:	(X3) DATE SURVEY COMPLETED			
		495257	B. WING			C <b>09/13/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	I	09/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 697	complete pain asset the pain may be sont than just a pain pill. may need to be seed out of the facility. In non-pharmacological stated nurses shoul an ice packs, heating document the offerences. LPN #3 stating interventions are not an as needed pain to because sometimes interventions cannot the location or kind to offer non-pharmacan be attempted.  On 09/12/2023 at a (administrative stafff ASM #2, director of clinical coordinator, above findings.  No further information.  References: (1) Tramadol is use moderately severe pobtained from the whittps://medlineplus.ml.	ssment. LPN #3 stated a ssment is important because mething that requires more LPN #3 stated the resident en by a doctor or transferred in regard to all interventions, LPN #3 doffer interventions such as ag pads or repositioning, and ed interventions in the nurses' ed non-pharmacological et always attempted each time medication is administered as non-pharmacological to be attempted depending on of pain, but nurses should try acological interventions if they proximately 5:07 p.m., ASM member) #1, administrator, nursing and ASM #3, regional were made aware of the on was provided prior to exit.  In this information was rebsite:  gov/druginfo/meds/a695011.ht  on form of arthritis. It causes reduced motion in your joints. oint, but usually it affects your or spine. This information	F	697		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		495257	B. WING _			C <b>09/13/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113	·	09/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 697	Based on resident in facility document review, the facility so complete pain mana 37 residents in the sand #7.  The findings included 1. For Resident #87 to initiate a complete to attempt non-pharmate when the as needed was administered or 2023.  On the most recent quarterly assessment reference date) of 90 out of 15 on the BIM status), indicating the intact for making da A review of R87's cliphysician's order damg (milligrams)- one hours as needed for September 2023 MAR record) revealed the as needed ibuprofer 9/4/23, 9/6/23, 9/7/2 of R87's clinical record 2023 MAR and Sepfailed to reveal a con (including location, completed on all data and sepfailed to reveal a con (including location, completed on all data and sepfailed to reveal a con (including location, completed on all data and sepfailed to reveal a con (including location, completed on all data and sepfailed to reveal a con (including location, completed on all data and sepfailed to reveal a con (including location, completed on all data and sepfailed to reveal a con (including location) and the review of the service of the se	gov/osteoarthritis.html. Interview, staff interview, view and clinical record aff failed to implement a gement program for two of survey sample, Residents #87  :  (R87), the facility staff failed a pain assessment and failed macological interventions a pain medication ibuprofen in multiple dates in September  MDS (minimum data set), a not with an ARD (assessment vi/23, the resident scored 15 ils (brief interview for mental e resident was cognitively illy decisions.  Inical record revealed a sted 1/20/23 for ibuprofen 200 e tablet by mouth every six as pain. A review of R87's are (medication administration in resident was administered in on 9/1/23, 9/2/23, 9/3/23, 3 and 9/8/23. Further review ord (including the September tember 2023 nurses' notes) impleter pain assessment quality and duration) was sees and failed to reveal all interventions were offered	F6	97		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495257	B. WING _				C <b>13/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	ÞΕ	1 00/	10/2020
THE LAUE	RELS OF WILLOW CREE	K		11611 ROBIOUS ROAD			
THE EAST	CLO OF WILLOW ORLL			MIDLOTHIAN, VA 23113			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA		(X5) COMPLETION DATE
F 697	Continued From page	<b>⇒</b> 56	F6	697			
	the nurses ask the readministering ibuprofithe location and description and de	R87 stated that sometimes sident's pain level prior to en but the nurses do not ask ription of the pain. R87 ses do not offer interventions.  m., an interview was (licensed practical nurse) #3. ior to administering an as ion, the nurses should ask to pain is, ask the resident if for sharp, ask the resident to resident if the pain is new, all indicators of pain, and ment. LPN #3 stated a sment is important because ething that requires more LPN #3 stated the resident by a doctor or transferred regard to interventions, LPN #3 offer interventions such as pads or repositioning, and interventions in the nurses' dinon-pharmacological always attempted each time edication is administered					
		g) were made aware of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(XS	(X3) DATE SURVEY COMPLETED			
		495257	B. WING _			C <b>09/13/2023</b>
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		09/13/2023	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 698 SS=D	documented, "1. Upo quarterly, with a signi and PRN (as needed for pain by the license residents will be mori pain and evaluated w condition and whenevexacerbation of pain iresident for indicators include: -Moaning, crying, and -Wincing or frowning -Body posture such a area of the body, or ly -Decrease in usual acts. Ask the resident ar frequency of pain: -No pain -Pain less than daily -Pain daily 7. Ask the resident ar location of pain 9. Each resident iden Pain Management Cahave: Individualized in resident's individual cashould include both p non-pharmacological, Complementary and pain management into Dialysis CFR(s): 483.25(I) Dialysis.	d, "Pain Management" n admission/re-admission, ficant change in condition ) residents will be evaluated ed nurse. 2. Additionally, tored for the presence of hen there is a change in ver new pain or an s suspected. 3.Observe of pain (refer to table 3),  I other vocalizations and other facial expressions s guarding or protecting an ving very still citivities and observe to determine the  tified with pain will have a are Plan. The care plan will interventions related to that control of pain management harmacological, and include Alternative Medicine (CAM) erventions"	F 6			10/16/23
		re that residents who				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE S COMPL	
		495257	B. WING			C 09/1	3/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1 03/1	3/2023
				11611 ROBIOUS ROAD			
THE LAUF	RELS OF WILLOW CREE	K		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 698	Continued From page	e 58	F 69	98			
	with professional star comprehensive personal star comprehensive personal star the residents' goals a This REQUIREMENT by: Based on staff intervand facility document that the facility staff facommunication with the dialysis visit for one of	is not met as evidenced iew, clinical record review review, it was determined		<ol> <li>Resident #91 no longer resifacility.</li> <li>Residents having dialysis wi audited to ensure communicatic completed for each resident or days.</li> </ol>	ill be ion is		
	9/9/23; and incomplete sheets for 8/29/23 and The facility policy, "He This policy document receiving hemodialys post treatment, and reinterventions4. The appropriate section of communication form receiving each dialysis the guest/resident ret."  A review of the clinical dated 8/21/23 for dial Wednesday, and Frid 8/30/23 changing the Thursday and Saturd.	s for 8/31/23, 9/2/23 and the dialysis communication of 9/5/23.  emodialysis" was reviewed. The dialysis was reviewed. The dialysis will be assessed pre and eceive necessary to facility completes the facili		3. Licensed nurses will be re-e completing dialysis communication residents who go to dialysis 9, 2023 by the ADON/ Designed 4. DON/designee will conduct a residents who attend dialysis 3 weekly times 2 weeks, weekly weeks and monthly times 2 more ensure communication sheets completed. A review of the find taken to QAPI for 3 months to compliance and will follow the recommendations.	ation she s by Octo ee. audits of s times times 2 onths to are dings will ensure	eets ober	
		8/27/23 that documented, er that his dialysis has					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		495257	B. WING_			C <b>09/13/2023</b>
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	<u> </u>	03/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 698	Thursday, Saturday, 8/29/2023" This is order changing the communication was communication sheet the facility on 8/25/2 change was initiated 8/25/23 or by the residialysis on 8/25/23.  A review of the dialy revealed the communication any of dialysis center to the the resident's name for this resident.  The dialysis sheet dialysis sheet dialysis sheet of the resident's name applicable for this resident.  The dialysis sheet dialysis she	ar and Sat (Tuesday, starting on Tue is in support of the above dialysis days.  In not included on the dialysis et from the dialysis center to it is not documented if this by the dialysis center on sident in the days following inication sheet dated 8/29/23 communication from the etacility and did not contain to validate that it was even into validate that it was sident.  Alled there was no etacted 8/31/23, 9/2/23 and interview was #1 (Licensed Practical that there should be cation sheets for every visit knows what is going on with interview was #4 (Registered Nurse), the	F6	98		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED
		495257	B. WING _		C 09/13/2023
	## A BUILDING  ## OF PROVIDER OR SUPPLIER  ## LAURELS OF WILLOW CREEK  ## SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ## Government of the Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided.  ## A BUILDING  ## B. WING    STREET ADDRESS, CITY, STATE, ZIP CODE   1611 ROBIOUS ROAD   MIDLOTHIAN, VA 23113    PROVIDER'S PLAN OF CORREC   (EACH CORRECTIVE ACTION SHO)   CROSS-REFERENCED TO THE APPR DEFICIENCY)  ## F 698    F 698    F 698    F 698    F 698    On 9/13/23 at 11:23 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided.    On 9/13/23 at 11:23 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided.				1 00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROP	D BE COMPLETION
F 698	Continued From pag	e 60	F 6	98	
F 700 SS=D	Staff Member) the Ad Director of Nursing, Clinical Coordinator, findings. No further On 9/13/23 at 11:23 Staff Member) the Ad Director of Nursing, Clinical Coordinator, findings. No further Bedrails CFR(s): 483.25(n)(1 §483.25(n) Bed Rails The facility must atter	dministrator, ASM #2 the and ASM #3, the Regional were made aware of the information was provided.  AM, ASM #1 (Administrative dministrator, ASM #2 the and ASM #3, the Regional were made aware of the information was provided.  )-(4)  s. empt to use appropriate	F 7	00	10/16/23
	a bed or side rail is a correct installation, or rails, including but no elements.  §483.25(n)(1) Assess entrapment from bed sentrapment from bed bed rails with the respresentative and of to installation.  §483.25(n)(3) Ensurare appropriate for the sentrapment from the sentrapment from bed and a sentrapment from bed for installation.	used, the facility must ensure use, and maintenance of bed on limited to the following so the resident for risk of drails prior to installation.  We the risks and benefits of sident or resident obtain informed consent prior that the bed's dimensions are resident's size and weight.  We the manufacturers' and specifications for installing			

	MENT OF DEFICIENCIES LAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  (X3) DATE COMP						
		495257	B. WING _			09/1	) 13/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE		
				11611 ROBIOUS ROAD			
THE LAUF	RELS OF WILLOW CREE	ĒΚ.		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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI		(X5) COMPLETION DATE
F 700	interview, facility doc record review, the face bed rail requirements residents in the surver. The findings include:  For Resident #87 (Resident #87 (Resident and obtain in the context of the resident and obtain in the context of the finding includes of the finding includes of the finding dail of the find	on, resident interview, staff ument review, and clinical cility staff failed to ensure all sewere met for one of 37 bey sample, Resident #87.  87), the facility staff failed to benefits of bed rails with the informed consent.  MDS (minimum data set), a at with an ARD (assessment 1/23, the resident scored 15 so (brief interview for mental eresident was cognitively y decisions.  Inical record revealed a led 2/17/23 for a right assist in turning and repositioning. In aluation dated 2/20/23 of an assist bar enabled ty and enabled the resident  I.m., R87 was observed lying sist bar in the upright  I.m., an interview was When asked, the resident to staff had not explained the the assist bar until about an	F 7	1. Resident #87 immediar review of the risks and be rails and signed consent for 2. Residents with grab barto ensure they have had robenefits of bed rails review signed consent for grab be resident noted not to have will be implemented.  3. Licensed Nurse will be ensuring a review of the ribed rails and signed consent for grab by the ADON/ designee.  4. DON/designee will concresidents with grab bars 3 times 2 weeks, weekly time monthly times 2 months to review of the risks and be rails and signed consent for the property of the finding taken to QAPI for 3 month compliance and will follow recommendations	nefits of bed or grab bars.  rs will be aud isks and wed and have ars. Any a a sign conserved as and beneal to grab be a sign conserved an efits of bed or grab bars I ings will be as to ensure	e a ent on efits ears 3	
	conducted with R87. stated that the facility risks and benefits of	When asked, the resident					

STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		I'V /		E SURVEY IPLETED	
				_		,	С	
		495257	B. WING			09/	13/2023	
NAME OF PROVIDE	ER OR SUPPLIER	EK		11	TREET ADDRESS, CITY, STATE, ZIP CODE 1611 ROBIOUS ROAD IIDLOTHIAN, VA 23113			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
On Scond LPN perm som eduction and on Stafff (the above facility residence facility resid	ducted with LPN at #3 stated the number of t	m., an interview was (licensed practical nurse) #3. Irses have to get special Ints to use assist bars and Ing department should Out the use of assist bars consent.  m., ASM (administrative e administrator) and ASM #2 Ing) were made aware of the  ed, "Side Rail/Bed/Mattress ical Requirements" Iside rail is implemented the formed consent from the Inceled, the resident Inceled the reside		725			10/16/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		495257	B. WING			C 09/13/2023		
	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	<b>. '</b>	00/10/2020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 725	resident care plans: (i) Except when waive this section, licensed (ii) Other nursing per limited to nurse aides §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by:  Based on observation interview, clinical record determined that the factorial survey sample, Resident was a survey sample, Resident #24 (Risprovide incontinence nursing staff.  R24 was admitted to that included but were wasting and abnormation on 09/11/23 at 12:35 revealed that R24, what the facility, activate incontinence care.  On 09/11/23 at 12:45	ed under paragraph (e) of unurses; and sonnel, including but not is.  It when waived under section, the facility must nurse to serve as a charge of duty.  It is not met as evidenced on, resident interview, staff ord review, it was facility staff failed to maintain of to ensure a resident's one of 37 residents in the dent #24.  24) the facility staff failed to care due to insufficient  the facility with diagnoses of enot limited to: muscle failities of gait and mobility.  It is p.m., an observation of p.m., an observation of the call bell for	F 72	1. Facility is now providing adec staffing to ensure resident needs 2. A meeting will be conduct to remaster schedule to ensure staffineet residents need. 3. DON and Staffing Coordinator re-educated by October 9, 2023 staffing is adequate to provide neare to meet the residents □ nee Administrator/designee. 4. Administrator/designee will coaudits of nursing staff 3 times we times 2 weeks, weekly times 2 wonthly times 2 months to ensure is adequate to provide nursing cresidents. A review of the finding taken to QAPI for 3 months to ercompliance and will follow the correcommendations.	eview the ng to  r will be to ensure ursing ads by the eekly weeks and re staffing are to gs will be nsure			
	revealed CNA (certifi	ed nursing assistant) #2 turned off the call and left						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495257	B. WING		ا ا	C <b>9/13/2023</b>
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113	1 0	9/13/2023
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 64	F 72	25		
	revealed LPN (licen	:00 p.m., an observation used practical nurse) #4 u and provided incontinence				
	documented eight of were scheduled for	rked schedule for 09/11/2023 certified nursing assistants the 7:00 a.m. to 3:00 p.m. est unit and four on the east				
	conducted with R24 entering her room F	7 p.m., an interview was When asked about CNA #2 R24 stated that she told CNA t and needed to be cleaned.				
	interview was condinursing assistant) # entering R24's room the day before, she R24's meal tray and clean her up. CNA that when she finish she would come ba care. When asked up the meal trays, 0 1:00 p.m. but could When asked why R incontinence care C	roximately 1:06 p.m., an ucted with CNA (certified 2. When asked about her n at approximately 12:45 p.m., stated that she picked up d that R24 asked if she would #2 stated that she told R24 ned picking up the meal trays ck and provide incontinence what time she finished picking CNA #2 stated that it was after not recall the exact time. 24 had to wait for CNA #2 stated that the unit nd that there were three CNAs				
	interview was condi- coordinator. When staffing requiremen	pproximately 4:16 p.m., an ucted with CNA #1, staffing asked to describe the minimal ts to provide adequate and care CNA #1 stated that with				

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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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	the west unit and six during the 7:00 a.m. the LPNs (licensed practicular during the 7:00 a.m. the LPNs (licensed practicular the total asked about the staffing she stated that there the units, and explain CNAs drop to property of the units, and explain CNAs drop to property of the units, and explain CNAs drop to property of the units, and explain CNAs drop to property of the units, and explain CNAs drop to property of the units, and explain to the units, and explain the units of the units, and units of the u	ere should be six CNAs on CNAs on the east unit to 3:00 p.m. shift and two ical nurses) on each unit to 3:00 p.m. shift. When ing on Monday, 09/11/2023, were four CNAs on each of ed that the facility has had needed) status, some have CNAs call out. When asked he short staffing CNA #1 staff who are off trying to get over and that the facility does When asked if not enough e quality of resident care  Proximately 5:07 p.m., ASM member) #1, administrator, ursing and ASM #3, regional were made aware of the  In was provided prior to exit. In the facility has provided prior to exit. In the faci		732			10/16/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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F 732	vocational nurses (a (C) Certified nurse a (iv) Resident census §483.35(g)(2) Postir (i) The facility must proceed in paragraph and provided in paragraph and paragraph and provided in paragraph and pa	al nurses or licensed is defined under State law). ides.  Ig requirements.  Ig requi	F 7	1. Posted nurse staffing information being posted daily.  2. No other concern noted.  3. Staffing coordinator and DON re-educated on posting nurse stainformation daily by October 9, 20 the Administrator/designee.  4. Administrator will conduct audiposted nurse staffing information	will be ffing 023, by ts of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495257	B. WING			C 09/13/2023	
	ROVIDER OR SUPPLIER	ĸ		STREET ADDRESS, CITY, STATE, ZIP CO 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	DDE	30/10/2020	
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F 732	On 9/11/2023 at 2:19 made of the facility's staff posting dated 9/On 9/11/2023 at 4:30 made of the facility's staff posting dated 9/On 9/12/2023 at 8:19 made of the facility's staff posting dated 9/On 9/12/2023 at 10:0 conducted with ASM member) #2, the direstated that the scheduling conthe floor as an aid administrator had beestaffing. She stated that the scheduling conthe floor as an aid administrator had beestaffing. She stated that the front of the staffing sheet from the posted it at the front of morning. She stated should be posted each aware of the observadated 9/7/2023 obser 9/12/2023 and stated. The facility policy, "Rerevised 4/19/2022 do facility posts the total worked of licensed and directly responsible for each shift. The inform prominent location the accessible by guests/Posting Requirement i. The facility will posts	p.m., an observation was lobby which revealed the 7/2023. p.m., an observation was lobby which revealed the 7/2023. p.m., an observation was lobby which revealed the 7/2023. p.m., an observation was lobby which revealed the 7/2023.  0 a.m., an interview was (administrative staff ctor of nursing. ASM #2 uling coordinator posted the en they arrived. She stated cordinator had been working e so she and the en assisting to post the hat they filled out a daily e master schedule and desk in the lobby each that the daily staff posting which day. ASM #2 was made tions of the staff posting ved on 9/11/2023 and that she was aware.  Required Regulatory Postings" cumented in part, "The number and actual hours and unlicensed nursing staff or guest/resident care for nation will be displayed in a lat is clearly visible and (residents, family and staff	F 73	weekly times 2 weeks, wee weeks and monthly times 2 ensure nurse staffing inform posted daily. A review of the be taken to QAPI for 3 mon compliance and will follow t recommendations.	months to nation is e findings will ths to ensure		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495257	B. WING			l	C 13/2023
	ROVIDER OR SUPPLIER		-	11	TREET ADDRESS, CITY, STATE, ZIP CODE  1611 ROBIOUS ROAD  IIDLOTHIAN, VA 23113	<u>  09/</u>	13/2023
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F 732	#1, the administrator, nursing and ASM #3, coordinator, were ma	oximately 5:10 p.m., ASM ASM #2, the director of the regional clinical de aware of the concern.	F	732			
F 755 SS=E		n was presented prior to exit. cedures/Pharmacist/Records (1)-(3)	F	755			10/16/23
	drugs and biologicals them under an agree §483.70(g). The facil personnel to administ	ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed					
	pharmaceutical service that assure the accurate dispensing, and admit	es. A facility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and ne needs of each resident.					
	• ,	onsultation. The facility n the services of a licensed					
	§483.45(b)(1) Provide aspects of the provisi the facility.	es consultation on all on of pharmacy services in					
		shes a system of records of n of all controlled drugs in able an accurate					
	§483.45(b)(3) Determ	nines that drug records are in					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	
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	ROVIDER OR SUPPLIER	ĸ		11	REET ADDRESS, CITY, STATE, ZIP CODE 611 ROBIOUS ROAD IDLOTHIAN, VA 23113	1 09/	13/2023
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	order and that an accis maintained and per This REQUIREMENT by: Based on staff intervand clinical record revolution to provide pharmacy residents in the surversidents in the sur	count of all controlled drugs riodically reconciled.  Tis not met as evidenced riew, facility document review view, the facility staff failed services for one of 37 ry sample, Resident #310.  All 10), the facility staff failed record revealed a red 2/17/23 for alpha-lipoic grams)- one capsule by refor supplement. A review resultable for alpha-lipoic acid. On revealed the same alpha-lipoic acid. On revealed the same alpha-lipoic acid. On revealed the code, resultable for altiple dates in February revealed the same alpha-lipoic acid. On revealed the same alpha-lipoic acid. On revealed the code, resultable for altiple dated the code, resultable for altiple for	F 7	755	1. Resident #310 no longer resides in facility.  2. An audit will be conduct of the MARs the prior 30 days for not administered medications. Providers will be notified any missed medications.  3. Licensed nurses will be re-educated October 9, 2023 on the process of obtaining medications from the pharma and the procedures on when the medications are not readily available by the ADON/designee.  4. DON/designee will conduct audits of the MAR for not administered medication the clinical meeting 3 times weekly times 2 weeks, weekly times 2 weeks a monthly times 2 months to ensure medications are given in accordance with written orders of the provider. A review the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	s of  by  acy  cons  and  with  of	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495257	B. WING		C 09/13/2023
	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113	1 00/10/2020
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F 755	a physician's dated a suspension 50 mcg both nostrils two time of R310's February 2 physician's order for doses on 2/18/23 and documented the cod Notes." A nurse's not documented the merpharmacy. A nurse's documented the merpharmacy and would administration time.  Further review of R3 a physician's order of (3) 25 mg- one table for bladder spasms. 2023 MAR revealed for Mirabegron. For 2/21/23 and 2/22/23 code, "5=Hold/See N dated 2/22/23 docur for delivery of the modulated alpha-limited Mirabegron were not on 9/12/23 at 3:20 pc conducted with LPN LPN #3 stated if a mathematication supply, a available in the supplemental supplication supply, a available in the supplemental	2017/23 for Flonase (2) nasal (micrograms)- one spray in es a day for allergy. A review 2023 MAR revealed the same Flonase. For the morning d 2/22/23, the MAR e., "5=Hold/See Nurse ote dated 2/18/23 dication was in route from the se note dated 2/22/23 dication was in route from the desired be given at the next at 10's clinical record revealed lated 2/20/23 for Mirabegron to by mouth two times a day A review of R310's February the same physician's order the morning doses on the MAR documented the lates Notes." A nurse's note mented the staff was waiting edication from the pharmacy. The same physical substitutes and the staff was waiting edication from the pharmacy. The same physical substitutes and the staff was waiting edication from the pharmacy. The same physical substitutes are physical substitutes and the staff was waiting edication from the pharmacy. The same physical substitutes are physical substitutes and the substitutes and the substitutes are physical substitutes and the substitutes and the substitutes and the substitutes are physical substitutes and the substitutes and the substitutes are physical substitutes and the substitutes and the substitutes and the substitutes and the substitutes are physical substitutes and the substitutes and the substitutes and the substitutes and the substitutes and	F 75	5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03	113/2023	
THE LALIE	RELS OF WILLOW CREE	K		11611 ROBIOUS ROAD			
THE LAUN	CLS OF WILLOW CKLL	N.		MIDLOTHIAN, VA 23113			
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F 755	Continued From page	<del>2</del> 71	F 7	55			
	staff member) #1 (the	m., ASM (administrative administrator) and ASM #2 g) were made aware of the					
	administered in accor the attending physicia policy titled, "Providin Services" documente Facility with the Facili set forth in the "Facility which details how Fac	mented, "Medications are dance with written orders of m." The facility pharmacy g Pharmacy Products and d, "Pharmacy will provide ty-specific information Sheet by-Specific Information Sheet					
F 757 SS=E	for nerve pain in peop information was obtai https://medlineplus.go (2) Flonase is used to information was obtai https://medlineplus.go tml (3) Mirabegron is use bladder. This informative website: https://medlineplus.go tml	ov/druginfo/natural/767.html o relieve allergies. This ned from the website: ov/druginfo/meds/a695002.h d to treat overactive ation was obtained from the ov/druginfo/meds/a612038.h e from Unnecessary Drugs	F 7	57		10/16/23	
33-E	§483.45(d) Unnecess Each resident's drug						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495257	B. WING _				C <b>13/2023</b>
	ROVIDER OR SUPPLIER	EK		1	TREET ADDRESS, CITY, STATE, ZIP CODE 1611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	, 00.	10,2020
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F 757	Continued From page	e 72	F	757			
	§483.45(d)(1) In exce duplicate drug therap	essive dose (including by); or					
	§483.45(d)(2) For ex	cessive duration; or					
	§483.45(d)(3) Withou	ut adequate monitoring; or					
	§483.45(d)(4) Withou use; or	at adequate indications for its					
	§483.45(d)(5) In the consequences which reduced or discontinu	indicate the dose should be					
	stated in paragraphs section.	ombinations of the reasons (d)(1) through (5) of this Γ is not met as evidenced					
	and facility document that the facility staff fa were free from unnec	view, clinical record review t review, it was determined ailed to ensure residents cessary medications for four e survey sample; Residents #7.			Resident #7 order for tramadol has been changed to scheduled. Resident #100, Resident #88 and Resident #91 longer reside in the facility.  2 An audit will be conducted on resider		
	The findings include:				who are administered PRN pain medications to ensure MD orders with parameters are being followed and		
	reviewed. This policy "Anticoagulant therap and treatment of venembolism, thrombotic with embolism and prembolism after Myoc inhibit the development."	nticoagulant Therapy" was y documented, by is utilized as a prophylaxis ous thrombosis, pulmonary c disorders, Atrial-Fibrillation rophylaxis of systemic ardium Infarction. They ent of a thrombus5.			include non-pharmacological interventi are offered/attempted. An audit will also be conducted on residents on anti-coagulants to ensure orders include monitoring of anti-coagulant for side effects, to include bleeding and bruising 3 Licensed Nurses will be re-educated October 9, 2023 regarding residents will	o le g. by	
	embolism, thrombotic with embolism and polembolism after Myoc inhibit the developme	c disorders, Atrial-Fibrillation rophylaxis of systemic ardium Infarction. They ent of a thrombus5. ulant therapy monitor the			monitoring of anti-coagulant for side effects, to include bleeding and bruising 3 Licensed Nurses will be re-educated	g. by ho	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	:K		11	TREET ADDRESS, CITY, STATE, ZIP CODE 1611 ROBIOUS ROAD IIDLOTHIAN, VA 23113	1 001	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	noted, hold anticoague physician immediately 1. For Resident #100 monitor for the use of medication.  A review of the clinical dated 8/25/23 for Eliquis 5 m.  A review of the composite revealed one dated 8 is at risk for abnormal (related to): medication care plan included the for "Administer medicated replan included the for "Administer medicated 8/25/23 for "Obphysician PRN (as-nessymptoms) of complication physician PRN (as-nessymptoms) of complication in urine, black to red blood in urine, black to red blood in stools, sun ausea, vomiting, dialethargy, bruising, blue of breath), Loss of apmental status, signification v/s (vital signs), bleed or abdominal pain and Further review of the reveal any evidence of use of an anticoagular	I symptoms of bleeding are plant medication and notify y."  O, the facility staff failed to an anticoagulant  al record revealed an order quis (1) 5 mg (milligrams) days; and an order dated gonce daily.  The energy of the energy of the physician and one of the physician and cations: blood tinged/frank that the physician and cations: blood tinged/frank that the physician and one of the physician and cations: blood tinged/frank that the physician and cations: blood tinged/frank that the physician and cations are point pain, and the physician and the ph	F	757	MD orders with parameters are followe and include non-pharmacological intervention are offered/attempted and documented and residents on anti-coagulants MD orders include monitoring of anti-coagulant for side effects, to include bleeding and bruising by the ADON/designee.  4 DON/designee will conduct audits of MAR of residents with PRN pain and anti-coagulants medications in the daily clinical meeting, 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure PRN pain medications MD orders with parameters are being followed and documented non-pharmacological intervention are offered/ attempted prio administering PRN pain medication and anti-coagulant have MD orders and documentation of anti-coagulant being monitored for side effects, to include bleeding and. A review of the findings we taken to QAPI for 3 months to ensur compliance and will follow the committer recommendations.	g the /2 I r to d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495257	B. WING _			C 9/13/2023	
	ROVIDER OR SUPPLIER	EEK		STREET ADDRESS, CITY, STATE, ZIP CO 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		371372323	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE CROSS-RE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 757	conducted with LP Nurse). She stated bruising, bleeding, that monitoring she just a one-time che be documented in are not any signs a nurse practitioner is stated that if there you can ask the documented with LP should watch for bup blood, bleeding unusual places, che that evidence of m progress notes and there should be a roccurred so others on with the resider.  On 9/13/23 at 11:0 conducted with RN unit manager. She be monitoring for semedications. She documentation of the cannot say it is documented it is not on 9/13/23 at 11:2 Staff Member) the Director of Nursing Clinical Coordinate.	AM, an interview was N #6 (Licensed Practical d that nurses should "watch for things like that." She stated buld be throughout the day, not eck. She stated that it should the nurse's notes if there are or and symptoms and to let the know if there are any. She isn't an order for monitoring, ector and put it in yourself.  AM, an interview was N #7. She stated that nurses ruising of any kind, coughing profusely from a wound or ange in condition. She stated tonitoring is done by charting on d a skin note. She stated that note every day even if nothing will know what has been going it.  O AM, an interview was 1 #4 (Registered Nurse), the estated that each shift should ide effects of anticoagulant stated that there should be the monitoring. She stated that is being monitored; if it is not	F 7	757			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495257	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		09/13/2023	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 757	strokes or blood clots fibrillation (a condition irregularly, increasing in the body and possinot caused by heart valso used to prevent a blood clot, usually i embolism (PE; a bloowho are having hip rereplacement surgery treat DVT and PE and prevent DVT and PE the initial treatment is Information obtained	n is used help prevent in people who have atrial in in which the heart beats if the chance of clots forming ibly causing strokes) that is valve disease. Apixaban is deep vein thrombosis (DVT; in the leg) and pulmonary od clot in the lung) in people eplacement or knee Apixaban is also used to d may be continued to from happening again after is completed."	F 75	57			
	monitor for the use of medication.  A review of the clinical dated 8/5/23 for Apixing (milligrams) twice.  A review of the comprevealed one dated 3 at risk for abnormal bito): medication use. A plan included the intelliant "Administer medication ineffectiveness and significations to the physic for "Observe and repulations (as-needed) s/sx (significations: blood	al record revealed an order aban (1) (same as Eliquis) 5 daily for atrial fibrillation.  rehensive care plan /20/23 for "(Resident #88) is leeding/bruising R/T (related Anticoagulant." This care ervention, dated 3/20/23 for ons as ordered. Observe for ide effects, report abnormal ian" and one dated 3/20/23					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495257	B. WING _			l	C <b>13/2023</b>	
	ROVIDER OR SUPPLIER	K		STREET ADDRESS, CITY, STATE, ZIP COD 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	)E			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE	
F 757	vomiting, diarrhea, m bruising, blurred vision breath), Loss of appermental status, signific v/s (vital signs), bleed or abdominal pain an Further review of the reveal any evidence of use of an anticoagular related to risk of bleed side effects.  On 9/13/23 at 8:35 Al conducted with LPN and Nurse). She stated the bruising, bleeding, this that monitoring should just a one-time check be documented in the are not any signs and nurse practitioner knows tated that if there is reported to the conducted with LPN and should watch for bruising blood, bleeding prunusual places, chant that evidence of moniprogress notes and at there should be a not	e headaches, nausea, uscle joint pain, lethargy, in, SOB (shortness of tite, sudden changes in cant or sudden changes in ding gums, petechiae, back d nosebleeds."  clinical record failed to of nurses monitoring for the int medication side effects ding and bruising and other  M, an interview was #6 (Licensed Practical nat nurses should "watch for ings like that." She stated do be throughout the day, not in She stated that it should be nurse's notes if there are or if symptoms and to let the low if there are any. She in the norder for monitoring, for and put it in yourself.	F 7	757				
	On 9/13/23 at 11:00 A	AM, an interview was 4 (Registered Nurse), the						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		OATE SURVEY OMPLETED	
		495257	B. WING _			C 09/13/2023	
	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		1 03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 757	Continued From pag	ge 77	F 7	57			
	unit manager. She is be monitoring for sid medications. She sidocumentation of the she cannot say it is documented it is not on 9/13/23 at 11:23 Staff Member) the ADirector of Nursing, Clinical Coordinator findings. No further Reference:  (1) Eliquis - "Apixab strokes or blood clot fibrillation (a condition irregularly, increasing in the body and position to caused by heart also used to prevent a blood clot, usually embolism (PE; a blowho are having hip is replacement surgery treat DVT and PE and prevent DVT a	stated that each shift should be effects of anticoagulant tated that there should be emonitoring. She stated that being monitored; if it is not adone.  AM, ASM #1 (Administrative dministrator, ASM #2 the and ASM #3, the Regional were made aware of the information was provided.  an is used help prevent is in people who have atrial on in which the heart beats go the chance of clots forming sibly causing strokes) that is valve disease. Apixaban is a deep vein thrombosis (DVT; in the leg) and pulmonary and clot in the lung) in people replacement or knee of Apixaban is also used to and may be continued to a from happening again after its completed."					
	monitor for the use of medication.						
		cal record revealed a ted 9/11/23 for Coumadin (1)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO. 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		03/10/2020	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 757	Continued From pag	e 78	F 7	57			
	5 mg (milligrams) dai Wednesday, Thursda dated 9/11/23 for Cor Sunday, for atrial fibro A review of the comprevealed one dated 8 at risk for abnormal 8 to): medication use. A plan included the interplant included the inter	ally, on Monday, Tuesday, ay, and Friday; and an order umadin 9.5 mg Saturday and illation.  In the present the same of the sa					
	Nurse). She stated the bruising, bleeding, the that monitoring should just a one-time check be documented in the	M, an interview was #6 (Licensed Practical hat nurses should "watch for ings like that." She stated d be throughout the day, not c. She stated that it should e nurse's notes if there are or d symptoms and to let the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDIN		E CONSTRUCTION	COMPLETED	(X3) DATE SURVEY COMPLETED	
		495257	B. WING		09/13/20	23	
	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 COM	(X5) PLETION DATE	
F 757	stated that if there is you can ask the doc On 9/13/23 at 8:46 A conducted with LPN should watch for bruup blood, bleeding punusual places, chathat evidence of morprogress notes and there should be a no occurred so others won with the resident.  On 9/13/23 at 11:00 conducted with RN a unit manager. She is be monitoring for signedications. She st documentation of the she cannot say it is documented it is not On 9/13/23 at 11:23 Staff Member) the A Director of Nursing, Clinical Coordinator, findings. No further Reference:  (1) Coumadin - "War clots from forming of and blood vessels. It certain types of irreg prosthetic (replacements)	anow if there are any. She con't an order for monitoring, tor and put it in yourself.  AM, an interview was #7. She stated that nurses ising of any kind, coughing profusely from a wound or ringe in condition. She stated intoring is done by charting on a skin note. She stated that ote every day even if nothing will know what has been going  AM, an interview was #4 (Registered Nurse), the stated that each shift should be effects of anticoagulant stated that there should be emonitoring. She stated that being monitored; if it is not	F 757				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495257	B. WING		C 09/13/2023	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		09/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 757	lung)." Information obtaine https://medlineplus.tml 4. For R7, the facili prn (as needed) the within the physician parameters. R7 was admitted winot limited to osteod "Tramadol HCI (hyo (milligrams). Give 8 (eight) hours as n Order Date: 10/25/2 The eMAR (electror record) for R7 date the physician order review of the eMAR 50 mgs of Tramadol 08/01/2023, 08/03/2 and on 08/31/2023. The eMAR for R7 d documented the physician order review of the eMAR for	y embolism (a blood clot in the d from gov/druginfo/meds/a682277.h sity staff failed to administer a e pain medication Tramadol (1) ordered pain level sith diagnosis that included but arthritis of the knee (2).  If for R7 documented in part, throchloride) Tablet 50 MG (1) (one) tablet by mouth every eeded for Pain level 6-10. 2022."  Inic medication administration d August 2023 documented as stated above. Further a revealed that (R7) received 1 for a pain level of five on 2023, 08/05/2023, 08/27/2023  atted September 2023 ysician order as stated above. e eMAR revealed that (R7) framadol for a pain level of	F 75			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	COMPLETED
		495257	B. WING		C 09/13/2023
	ROVIDER OR SUPPLIER	EK		STREET ADDRESS, CITY, STATE, ZIP CODE  11611 ROBIOUS ROAD  MIDLOTHIAN, VA 23113	7 33/10/2020
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 757	asked if the pain me administered accord for the dates listed a and that the medicat of the physician's ord.  On 09/12/2023 at ap (administrative staff ASM #2, director of clinical coordinator, vabove findings.  No further information.  References: (1) Tramadol is used moderately severe pobtained from the we https://medlineplus.gml.  (2) The most commodpain, swelling, and response to the date of the pain, swelling, and response to the date of the pain, swelling, and response to the date of the pain, swelling, and response to the date of the pain is the pain in the	r 2023 eMARS she was dication for R7 was ing to the physician's orders bove. ASM #2 stated no, ion was administered outside dered parameters.  proximately 5:07 p.m., ASM member) #1, administrator, nursing and ASM #3, regional were made aware of the  In was provided prior to exit.  It to relieve moderate to ain. This information was ebsite: gov/druginfo/meds/a695011.ht	F 7	57	
F 800 SS=D	hands, knees, hips, was obtained from the https://medlineplus.g. Provided Diet Meets CFR(s): 483.60  §483.60 Food and note that the facility must proportion nourishing, palatable meets his or her dail dietary needs, taking preferences of each	pov/osteoarthritis.html.  Needs of Each Resident  utrition services.  vide each resident with a e, well-balanced diet that y nutritional and special g into consideration the	F 8	00	10/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495257	B. WING				C 13/2023
NAME OF PR	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	13/2023
		V			1611 ROBIOUS ROAD		
THE LAUR	RELS OF WILLOW CREE	ĸ		M	IIDLOTHIAN, VA 23113		
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F 800	Continued From page by: Based on staff intervand clinical record reto provide a diet to mone of 37 residents in Resident #310.  The findings include: For Resident #310 (Resident #310)  The findings include: For Resident #310 (Resident #310)  The findings include: For Resident #310 (Resident #310)  discharged from the recommendation for a staff failed to obtain a diet until 2/20/23. R3  until a physician's ordinary ordinary ordinary of the physician's ordinary of the physician's orders and diagnosis of diabete physician's orders and diet as regular.  A facility form titled, "Employee, and Visito 2/20/23 documented, about? Diet. I am diagnosis."	iew, facility document review view, the facility staff failed eet a resident's needs for a the survey sample,  2310), the resident was nospital on 2/17/23 with a diabetic diet. The facility physician's order for R310's 10 was served a regular diet ler for a consistent a no added salt was  surgery progress note dated "Assessment/Plan: Diet:  to the facility on 2/17/23 with es. A review of R310's led to reveal any dietary A dietary communication ocumented the resident's  Guest/Resident, Family, r Assistance Form" dated "What is your concern beticWhen did the		800		the ure by ith the er ks, es	
	admission slip for gue Saturday, diet slip sta ACTION TO BE TAKI	E: Dietary received a new est on 2/18/23 which is a sted guest was a regular diet. EN: Dietary director will goeferences" A registered					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	' '	ATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER	EEK		STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113		307.107.2020
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F 800	documented, "Utilizar (diabetes mellitus) rought (diabetes mellitus) rough	evaluation dated 2/20/23 es insulin pump for DM management, follows a strict ) counting diet for DM" 310's clinical record revealed dated 2/20/23 for a consistent	F8	00		
	carbohydrate diet w prescribed on that d equivalent to a diab On 9/13/23 at 9:01 a conducted with OSM	ith no added salt was late. OSM #4 stated this was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495257	B. WING				C 1 <b>3/2023</b>	
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF WILLOW CREEK			1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 1611 ROBIOUS ROAD IIDLOTHIAN, VA 23113			
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F 812 SS=D	from the nursing staff dietary communication diet that is document form and provided to entered into the dieta the diet that is provid.  On 9/13/23 at 3:07 p. member) #1 (the admirector of nursing) was above concern.  The facility policy title documented, "1. The Physician order for the admission/readmission needed. 2. The Nurse written Diet Order and the change to the Dieter Food Procurement, SCFR(s): 483.60(i)(1)(1)(1)(1)(2)(2)(3)(3)(3)(4)(4)(4)(4)(4)(4)(5)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	diets are communicated for the dietary staff via on forms. OSM #5 stated the ed on the communication the kitchen is the diet that is any meal tracker system and ed.  Image: ASM (administrative staff ininistrator) and ASM #2 (the ere made aware of the ere made aware of the extension of the exten		800			10/16/23	

IDENTIFICATION NUME	DED: I`´	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
495257	B. WING		09/13/2023
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DEFICIENCY MUST BE PRECEDED BY F	ULL PREF		ION SHOULD BE COMPLETION DATE
2) - Store, prepare, distribute and in accordance with professional or food service safety.  IREMENT is not met as evidence observation, staff interview, and eview it was determined facility are food in a sanitary manner in orkitchens.  Is include:  Istaff failed to close a box contained ded fish filets, exposing them to be at, in one of one walk-in freezers with OSM (other staff member) are ager. Observation of the middle side inside the freezer revealed box of breaded fish filets. Observeded that the box and the inside was open to the environment. We much was left in the box OSM # out half remaining. OSM #1 furtified the box should have been closed or removed it from the freezer.  Is policy "Food Purchasing and ocumented in part, "All frozen food preserved."	d ced facility staff one of  ning a the , an vas #1, e shelf a vation ide //hen id her d and		be not sealed way  fill be conduct to the distance of the conduct to the walk-in the sealed walk-in the walk-in the sealed walk
Lotter I will the second of th	EDPPLIER  LOW CREEK  SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FOLATORY OR LSC IDENTIFYING INFORMATION OF LSC IDENTIFYING INFORMAT	JUPPLIER  LOW CREEK  SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL JUATORY OR LSC IDENTIFYING INFORMATION)  From page 85  Fom page 85  Fom page 85  Fom page 85  Fom page 85  For food service safety.  JUREMENT is not met as evidenced  observation, staff interview, and facility review it was determined facility staff ore food in a sanitary manner in one of kitchens.  Is include:  staff failed to close a box containing a added fish filets, exposing them to the ent, in one of one walk-in freezers.  023 at approximately 11:45 a.m., and of the facility's walk-in freezer was with OSM (other staff member) #1, mager. Observation of the middle shelf the side inside the freezer revealed a box of breaded fish filets. Observation revealed that the box and the inside was open to the environment. When much was left in the box OSM #1 out half remaining. OSM #1 further the box should have been closed and y removed it from the freezer.  Is policy "Food Purchasing and ocumented in part, "All frozen food will	STREET ADDRESS, CITY, STATE, ZIP OF 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113  SUMMARY STATEMENT OF DEFICIENCIES HOEFICIPY MUST BE PRECEDED BY FULL ILATORY OR LSC IDENTIFYING INFORMATION)  From page 85  F 812  2) - Store, prepare, distribute and in accordance with professional for food service safety. IllREMENT is not met as evidenced observation, staff interview, and facility review it was determined facility staff ore food in a sanitary manner in one of kitchens. Is include:  staff failed to close a box containing a daded fish filets, exposing them to the not, in one of one walk-in freezers.  22 at approximately 11:45 a.m., an of the facility's walk-in freezer was with OSM (other staff member) #1, mager. Observation of the middle shelf to side inside the freezer revealed a box of breaded fish filets. Observation revealed that the box and the inside was open to the environment. When much was left in the box OSM #1 out half remaining. OSM #1 further the box should have been closed and y removed it from the freezer.  Is policy "Food Purchasing and commented in part," All frozen food will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495257	B. WING			C 09/13/2023	
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF WILLOW CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE 11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113	1 03	113/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 812	clinical coordinator, wabove findings.	e 86 vere made aware of the n was provided prior to exit.	F	812			