| (X4) ID PREFIX TAG {E 000} | (EACH DEFICIENCY REGULATORY OR L Initial Comments An unannounced Me first revisit to the stan conducted on 6/11/18 conducted 8/7/18 thro found to be in complia 483.73, Requirement Facilities at the time of | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) dicare/Medicaid survey, a dard survey which was 3 through 6/15/18 was bugh 8/8/18. The facility was ance with 42 CFR Part | | STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) } | BE COMP | (X5) PLETION DATE |
|-------------------------------------|---|---|---------------------|--|-----------------|-------------------------|
| (X4) ID PREFIX TAG {E 000} | ELS OF UNIVERSITY PA SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Initial Comments An unannounced Me first revisit to the stan conducted on 6/11/18 conducted 8/7/18 thro found to be in complia 483.73, Requirement Facilities at the time of | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) dicare/Medicaid survey, a dard survey which was 3 through 6/15/18 was bugh 8/8/18. The facility was ance with 42 CFR Part | ID PREFIX TAG | 2420 PEMBERTON RD RICHMOND, VA 23233 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | N () BE COME | (X5) PLETION |
| (X4) ID PREFIX TAG {E 000} | SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Initial Comments An unannounced Me first revisit to the stan conducted on 6/11/18 conducted 8/7/18 thro found to be in complia 483.73, Requirement Facilities at the time of | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) dicare/Medicaid survey, a dard survey which was 3 through 6/15/18 was bugh 8/8/18. The facility was ance with 42 CFR Part | ID PREFIX TAG | RICHMOND, VA 23233 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMP | PLETION |
| PREFIX TAG {E 000} | (EACH DEFICIENCY REGULATORY OR L Initial Comments An unannounced Me first revisit to the stan conducted on 6/11/18 conducted 8/7/18 thro found to be in complia 483.73, Requirement Facilities at the time of | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) dicare/Medicaid survey, a dard survey which was through 6/15/18 was bugh 8/8/18. The facility was ance with 42 CFR Part | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMP | PLETION |
| | An unannounced Me first revisit to the stan conducted on 6/11/18 conducted 8/7/18 thro found to be in complia 483.73, Requirement Facilities at the time of | dard survey which was through 6/15/18 was ough 8/8/18. The facility was ance with 42 CFR Part | {E 000 |)} | | |
| | first revisit to the stand conducted on 6/11/18 conducted 8/7/18 thro found to be in complia 483.73, Requirement Facilities at the time of | dard survey which was through 6/15/18 was ough 8/8/18. The facility was ance with 42 CFR Part | | | | |
| | INITIAL COMMENTS | of the revisit survey. | {F 000 |)} | | |
| | first revisit to the stand conducted on 6/11/18 conducted 8/7/18 thro required for compliant Federal Long Term Ca Uncorrected deficience | ough 8/8/18. Corrections are ce with 42 CFR Part 483 | | | | |
| {F 580} | 132 at the time of the consisted of 15 currer Residents #101 throu | gh # 115. jury/Decline/Room, etc.) | {F 580 |)} | 8/31/ | '18 |
| | consult with the reside consistent with his or representative(s) whe (A) An accident involv results in injury and h physician intervention (B) A significant chan mental, or psychosoc | ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring o; ge in the resident's physical, | | | | |

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.

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | D: 09/04/2018 MAPPROVED O. 0938-0391 |
|--------------------------|---|--|--------------------|------|--|-----------|--|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | (X3) DATI | E SURVEY PLETED |
| | | 495109 | B. WING | | | 08 | R 8/08/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | • | | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | A PK | | 24 | 20 PEMBERTON RD | | |
| | | | | R | ICHMOND, VA 23233 | | |
| (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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| {F 580} | clinical complications (C) A need to alter treat a need to discontinue treatment due to adve commence 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 informati- is available and provi- physician. (iii) The facility must a resident and the resid when there is- (A) A change in room as specified in §483. ⁻ (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a comp- that is a composite di §483.5) must disclose its physical configural locations that compris- part, and must specifi room changes betwe- under §483.15(c)(9). | reatening conditions or); eatment significantly (that is, e an 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 also 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 5 | 580} | | | |
| | by: | iew, facility document review | | | The Laurels of University Park wish | nes to | |

Facility ID: VA0249

If continuation sheet Page 2 of 70

| | | MEDICAID SERVICES | | | OMB NO. 0938-03 |
|---------------|-------------------------------|---|---------------|---|-------------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| ID I LAN OI | CONTRECTION | DEIMINOATION NOMBER. | A. BUILDING | G | |
| | | 495109 | B. WING | | R |
| | | 495109 | | STREET ADDRESS, CITY, STATE, ZI | 08/08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 2420 PEMBERTON RD | PCODE |
| THE LAU | RELS OF UNIVERSITY P | ARK | | RICHMOND, VA 23233 | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN | OF CORRECTION (X5) |
| PRÉFIX TAG | | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | O THE APPROPRIATE DATE |
| {F 580} | Continued From page | e 2 | {F 58 | 03 | |
| (, | 10 | view, the facility staff failed | [1 00 | have this submitted plan | of correction |
| | | n of a change in condition for | | stand as its allegation of | |
| | one of 15 residents in | | | date of alleged complian | - |
| | Resident #103. | · · · · | | 2018 | |
| | The facility staff failed | d to notify the physician of | | Preparation and/or exec | ution of this plan |
| | | ated blood sugar of 500 on | | of correction does not co | |
| | 8/4/18. | | | admission to, nor agreer | |
| | The findings include: | | | the existence of or the s | |
| | The findings include: | | | of any of the cited deficience conclusions set forth in t | |
| | Resident #103 was a | admitted to the facility on | | deficiencies. This plan is | |
| | | es that included but were not | | executed to ensure cont | |
| | | , difficulty swallowing, | | with regulatory requirem | |
| | dementia without beh | navioral disturbance, type | | | |
| | | scle weakness. Resident | | | |
| | | IDS (minimum data set) | | | |
| | | uarterly assessment with an | | | |
| | | ference date) of 6/13/18. coded as being moderately | | Ftag 580 | |
| | | function scoring 11 out of 15 | | 1 tag 500 | |
| | | terview for mental status) | | Resident #103: No nega | tive outcome |
| | | 3 was coded as requiring | | occurred as a result of the | nis practice. The |
| | supervision only with | ADLS (activities of daily | | physician was notified of | f the elevated |
| | living). | | | blood sugar reading. | |
| | Review of Resident # | #103's August 2018 physician | | Diabetic residents in the | facility have the |
| | | mented the following orders: | | potential to be affected b | - |
| | | preakfast, lunch, dinner at | | | |
| | | Is and at bedtime. Notify MD | | DON or designee will ed | |
| | (medical doctor) of B | S <70 or >400. | | nursing staff on following parameters as ordered b | |
| | Humalog Solution (1 |) 100 UNIT/ML Inject per | | | |
| | | 200= 2 units; 201-250=4 | | DON or designee will au | dit MARs of |
| | units; 251-300=6 unit | | | current diabetics with or | |
| | | 01 -500= 12 units Call MD is | | sugar parameters for the | e last 14 days. |
| | | bcutaneously before meals | | | |
| | and at bedtime for di | abetes." | | DON or designee will me | |
| | | | | order changes 5 times a | WEEK TOP 4 |

Facility ID: VA0249

If continuation sheet Page 3 of 70

| STATEMENT | OF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · · | E CONSTRUCTION | OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------|--|--|
| | CONTECTION | IDENTIFICATION NOWDER. | A. BUILDING | | R |
| | | 495109 | B. WING | | 08/08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | |
| (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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE COMPLETIC |
| {F 580} | Review of Resident # (Medication Administr on 8/4/18 at 11:30 a.r sugar was 500. Furth revealed that Residen Humalog per order. the physician was ma #103's blood sugar re Review of the August evidence any docume was made aware that on 8/4/18. Resident #103's Bloo 12/20/17, documente fluctuation in blood su Guest will be free fron from fluctuation blood status changes, trem weakness, appetite to Interventions: "Admin orders. Observe for in effects. Report finding and document s/sx (s complications from flu Report abnormal find On 8/8/18 at 11:54 a. conducted with LPN (the nurse who worked 8/4/18. When asked meant, LPN #2 stated higher than 400, then be notified before giv scale insulin. When a documented anywhea | atio3's August 2018 MAR ation Record) revealed that m., Resident #103's blood her review of the MAR ht #103 received 12 units of There was no evidence that ade aware of Resident ading on 8/4/18. ation that the physician at her blood sugar was 500 d Sugar care plan dated d the following: "At risk for agars related to Diabetes. m signs of complications d sugars such as mental ors/shakiness, dizziness, bas thru next review date. aister medications per affectiveness and side gs to physician." m., an interview was (licensed practical nurse) #2, d with Resident #103 on what the above order d that if the blood sugar was the medical doctor should ing the 12 units of Sliding | {F 580 | Weeks. Additional education and/or counseling will be provided as indic Concerns will be reported by the DON/Designee to the quality assur committee. Continued compliance will be moni through the facility s quality assur program. Additional education and monitoring will be initiated for any identified concerns. Completion date: August 31, 2018 | cated. ance tored |

Facility ID: VA0249

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|--|--------------------|------|--|-------------------|----------------------------|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 495109 | B. WING | | | | R 1 08/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 580} | system and was still t (point click care). Wh notifying the physician Resident #103's blood stated she did not not she did not realize the to notify the physician gave the 12 units of so order. LPN #2 confirm was not followed. On 8/8/18 at 2:51 p.m member) #1, the adm (Director of Nursing), Transition Specialist, Director of Operations above concerns. Facility policy titled, "(the Physician" did not concerns. No further information (1) Humalog (insulin I human insulin analog glycemic control in ac diabetes mellitus. Th from The National Ins https://dailymed.nlm.r | ocumenting in the computer rying to figure out PCC hen asked if she could recall in on 8/4/18 regarding d sugar of 500, LPN #2 tify the physician because e order directed nursing staff h. LPN #2 stated she only diding scale insulin per med that the physician order h., ASM (administrative staff hinistrator, ASM #2, the DON ASM #3, the Clinical and ASM #4, the Regional is was made aware of the Observations to Report to t address the above h was presented prior to exit. | {F 5 | 580} | | | |
| {F 623} SS=D | Notice Requirements CFR(s): 483.15(c)(3)- | Before Transfer/Discharge -(6)(8) | {F 6 | 23} | | | 8/31/18 |
| | §483.15(c)(3) Notice | before transfer. | | | | | |

Facility ID: VA0249

If continuation sheet Page 5 of 70

| | | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 09/04/2018 1 APPROVED 0. 0938-0391 |
|--------------------------|--|---|-------------------|------|--|---|------|---|
| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | E CONSTRUCTION | | | LETED |
| | | 495109 | B. WING | | | | | २ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE | , ZIP CODE | - | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | | 420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORRECTIV CROSS-REFERENCE | AN OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY) | | (X5) COMPLETION DATE |
| {F 623} | Before a facility transf resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and mannel facility must send a cor representative of the Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the noti paragraph (c)(5) of th §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un made by the facility ar resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (C) The resident's her allow a more immedia under paragraph (c)(f (D) An immediate tran required by the resider under paragraph (c)(f) | fers or discharges a hust- and the resident's he transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State budsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or hder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; | {F 6 | 523} | | | | |

Facility ID: VA0249

If continuation sheet Page 6 of 70

| | MENT OF HEALTH AN S FOR MEDICARE & I | D HUMAN SERVICES | | | | FORM | 2: 09/04/2018 1 APPROVED 2: 0938-0391 |
|---|--|---|------------------------------|---------------------------------|---|-------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | 08/08/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | S | STREET ADDRESS, CITY, STAT | E, ZIP CODE | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECT CROSS-REFERENC | IVE ACTION SHOULD BE ED TO THE APPROPRIA | | (X5) COMPLETION DATE |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE LAURELS OF UNIVERSITY PARK STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLE | | | | | | | |
| | notice specified in par must include the follow (i) The reason for tran (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailing telephone number of the protection and address developmental disabil C of the Developmental and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility address and tel agency responsible for advocacy of individua established under the for Mentally III Individua §483.15(c)(6) Change If the information in the | ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; nich the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how rm and assistance in ind submitting the appeal s (mailing and email) and the Office of the State budsman; / residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental eabilities, the mailing and ephone number of the or the protection and Is with a mental disorder Protection and Advocacy uals Act. | | | | | |

Facility ID: VA0249

If continuation sheet Page 7 of 70

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | FORI | MAPPROVED |
|--------------------------|--|---|---------------------|---|---|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE COMF | E SURVEY PLETED |
| | | 495109 | B. WING | OMB NO. 093 AULTIPLE CONSTRUCTION (X3) DATE SURVE LDING (X3) DATE SURVE NG R NG STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233 ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COM DEFICIENCY) CROSS-REFERENCED TO THE APPROPRIATE F 623} Ftag 623 Resident # 103: No negative outcome has occurred from this practice. The resident has returned to the facility All residents have the potential to be affected. The DON or designee will educate licensed nursing staff on completing a transfer notice to ensure the resident representative is notified and given reason for the resident transfer in writing. The DON or designee will audit the last 14 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR | JLD BE | (X5) COMPLETION DATE |
| {F 623} | must update the recip as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility of the administrator of the written notification pri- to the State Survey A State Long-Term Care the facility, and the re- well as the plan for the relocation of the reside 483.70(I). This REQUIREMENT by: Based on staff interv- review, and clinical re- determined that facility written notification to for a facility initiated the residents in the surve The facility staff failed notification to Residen her reason for transfer The findings include: Resident #103 was ar 7/29/18 with diagnose limited to head injury, dementia without beh two diabetes and mus- #103's most recent M assessment was a qu ARD (assessment ref Resident #103 was con- | in advance of facility closure closure, the individual who is ne facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate ents, as required at § T is not met as evidenced iew, facility document coord review, it was y staff failed to provide the responsible party (RP) ransfer for one of 15 y sample, Resident #103. I to provide written nt #103's RP documenting r to the hospital on 7/28/18. | {F 62 | Ftag 623 Resident # 103: No negative outco occurred from this practice. The re has returned to the facility All residents have the potential to affected. The DON or designee will educate licensed nursing staff on completin transfer notice to ensure the reside representative is notified and giver for the resident transfer in writing. | sident be ng a ent n reason e last 14 or 4 ion and | |

Facility ID: VA0249

| STATEMENT | OF DEFICIENCIES F CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|---------------------|---|-------------------------------|--|--|
| | | 495109 | B. WING | | R 08/08/2018 | | |
| NAME OF F | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 00/00/2010 | | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETIC | | |
| {F 623} | on the BIMS (brief int exam. Review of Resident # revealed that she wen The following note wa "Loud noise from room her left side beside B front of her. Guest noted RP (responsible party transfer. Unable to re doctor) at this time. W Guest will be transpo Ambulance)." The next note dated T documented the follow plan/goals, and copy guest to ER (emergen There was no evidend the responsible party of Resident #103's ho Further review of the Resident #103 return with a diagnosis of a On 8/8/18 at 12:00 p. conducted with LPN (When asked about th a resident is transferr acute condition, LPN assess the patient, of the MD (medical doct party). LPN #1 stated rescue squad and set | erview for mental status) 103's clinical record 1 to the hospital on 7/28/18. as documented at 3:30 p.m., m 226. Guest noted lying on bed with rolling walker in ates, "I was trying to unlock d with increased confusion. /) notified of incident and ach on call MD (medical Vill continue to call MD. rted by (Name of 7/28/18 at 6:57 p.m., wing: "Bed hold policy, care of MARS/TARS sent with ncy room)." ce in the clinical record that received written notification ospital transfer. clinical record revealed that ed to the facility on 7/28/18 UTI (urinary tract infection). | {F 623 | been given. Checking hospital transf will remain a process of the clinical meeting. Additional education and/o counseling will be provided as indica Concerns will be reported by the DON/Designee to the quality assura committee. Continued compliance will be monitor through the facility squality assurant program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: August 31, 2018 | or ated. nce ored | | |

Facility ID: VA0249

If continuation sheet Page 9 of 70

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 1 APPROVED 0. 0938-0391 |
|--------------------------|---|--|---------------------|--|---|-------------------|---|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | F 08/ | ≺ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, STAT | FE, ZIP CODE | | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | 420 PEMBERTON RD CICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECT CROSS-REFERENC | PLAN OF CORRECTION FIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY) | | (X5) COMPLETION DATE |
| {F 623} | the RP was notified, L notified verbally. LPN send written notification On 8/8/18 at 1:07 p.m conducted with LPN # #7 stated that social s providing written notifi- party for a hospital trans On 8/8/18 at 1:25 p.m conducted with OSM director of social serv when a resident is trans OSM #2 stated that sid during a transfer to the that nursing was resp responsible party. On 8/8/18 at 1:41 p.m conducted with ASM member) #1, the adm that nursing was resp notification form with a time of transfer, and the responsible for mailing sheet to the RP. On 8/8/18 at 1:47 p.m conducted with OSM #4 stated that when a the hospital, she will r and then mail out a tra- explaining why the re- #4 stated that she will a reasonable timefram | PN #1 stated that RP was #1 stated that she does not on to the RP. a., an interview was #7, the unit manager. LPN services was responsible for ication to the responsible ansfer. a., an interview was (other staff member) #2, the ices. When asked her role nsferred to the hospital, he does not have a role e hospital. OSM #2 stated onsible notifying the a., an interview was (administrative staff inistrator. ASM #1 stated onsible for sending a written the resident to the RP at the hen medical records was g out a written notification a., an interview was #4, medical records. OSM a., an interview was #4, medical records. OSM b., an interview was stated to sheet sident was sent out. OSM b. send the notification sheet sident was sent out. OSM c. SSM #4 stated she kept ints that are sent to the RP. c. provide the transfer | {F 623} | | | | |

Facility ID: VA0249

If continuation sheet Page 10 of 70

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | D: 09/04/2018 M APPROVED D. 0938-0391 |
|--------------------------|---|---|--------------------|------|--|------------------|---|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , í | | CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 495109 | B. WING | | | | R / 08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | | 420 PEMBERTON RD RICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| {F 623} | Continued From page | 9 10 | {F 6 | 523} | | | |
| | | a., OSM #4 stated that she cation sheet for Resident | | | | | |
| | member) #1, the adm (Director of Nursing), Transition Specialist, Director of Operations | and ASM #4, the Regional s was made aware of the licy could not be provided | | | | | |
| {F 656} SS=D | Develop/Implement C CFR(s): 483.21(b)(1) | comprehensive Care Plan | {F € | 56} | | | 8/31/18 |
| | implement a compreh care plan for each res resident rights set for §483.10(c)(3), that ind objectives and timefra medical, nursing, and needs that are identifi assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483. provided due to the re under §483.10, includ treatment under §483. (iii) Any specialized se | sility must develop and lensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial red in the comprehensive aprehensive care plan must reto be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse .10(c)(6). ervices or specialized the nursing facility will | | | | | |

Facility ID: VA0249

If continuation sheet Page 11 of 70

| | | ND HUMAN SERVICES MEDICAID SERVICES | | | | FORI | D: 09/04/201 MAPPROVE D. 0938-039 |
|--------------------------|--------------------------|---|--------------------|------|---|----------|---|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | COM | E SURVEY PLETED R |
| | | 495109 | B. WING | | | | ™ /08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | RELS OF UNIVERSITY P | ARK | | 24 | 420 PEMBERTON RD | | |
| | | | | R | RICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| {F 656} | Continued From pag | e 11 | {F 6 | 3561 | | | |
| [| | a facility disagrees with the | 1 | lool | | | |
| | | RR, it must indicate its | | | | | |
| | rationale in the reside | | | | | | |
| | | th the resident and the | | | | | |
| | resident's representa | | | | | | |
| | - | als for admission and | | | | | |
| | desired outcomes. | | | | | | |
| | | eference and potential for | | | | | |
| | | cilities must document | | | | | |
| | | 's desire to return to the | | | | | |
| | - | essed and any referrals to es and/or other appropriate | | | | | |
| | entities, for this purpo | | | | | | |
| | | in the comprehensive care | | | | | |
| | | in accordance with the | | | | | |
| | | h in paragraph (c) of this | | | | | |
| | section. | | | | | | |
| | This REQUIREMEN | T is not met as evidenced | | | | | |
| | by: | | | | | | |
| | | view, facility document | | | Ftag 656 | | |
| | review, and clinical re | | | | | | |
| | determined that the f | - | | | Resident#103: No negative outcome | | |
| | | rehensive care plan for two | | | resulted from this practice. The physic | | |
| | #103, 106, and 108. | e survey sample, Resident | | | has been notified of the elevated bloo sugar reading | u | |
| | | | | | | | |
| | 1. The facility staff fa | iled to follow Resident #103's | | | Resident # 106: No negative outcome | ; | |
| | • | the physician of an abnormal | | | resulted from this practice. The cathe | | |
| | blood sugar. | | | | care schedule has been adjusted to the | | |
| | | | | | resident⊡s preference. | | |
| | | iled to provide care to the | | | | | |
| | | per the comprehensive care | | | Diabetic residents and residents with | | |
| | plan for Resident #10 | U6. | | | catheters have the potential to be affe | ected | |
| | The findings include: | | | | DON or designee will educate license | | |
| | | | | | nursing staff on notifying the physician | n of | |
| | | s admitted to the facility on | | | abnormal blood sugar readings and | | |
| | | es that included but were not | | | providing catheter care per the reside | nt | |
| | imited to head injury | , difficulty swallowing, | | | comprehensive care plan. | | |

Event ID: TEQ112

Facility ID: VA0249

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| STATEMENT (| OF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · · | LE CONSTRUCTION | OMB NO. 0938 (X3) DATE SURVE COMPLETED R | | |
|--------------------------|---|--|---------------------|---|---|-----------------------|--|
| | | 495109 | B. WING | | 08/08/20 | 18 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE LAUF | ELS OF UNIVERSITY P | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE COMP | X5) PLETION ATE | |
| {F 656} | two diabetes and mus #103's most recent M assessment was a qu ARD (assessment ref Resident #103 was co impaired in cognitive on the BIMS (brief int exam. Resident #103 supervision only with living). Review of Resident # order summary docur "Accu check before b bedtime. before meal (medical doctor) of B3 Humalog Solution (1) sliding scale: If 150-2 units; 251-300=6 unit 351-400=10 units; 40 (sic) BS over 400, sul and at bedtime for dia Review of Resident # (Medication Administion on 8/4/18 at 11:30 a.r sugar was 500. Furth revealed that Resider Humalog per order. The physician was ma reading on 8/4/18. Review of the August | avioral disturbance, type scle weakness. Resident IDS (minimum data set) parterly assessment with an ference date) of 6/13/18. oded as being moderately function scoring 11 out of 15 review for mental status) was coded as requiring ADLS (activities of daily and the following orders: reakfast, lunch, dinner at s and at bedtime. Notify MD S <70 or >400. 100 UNIT/ML Inject per 00= 2 units; 201-250=4 s; 301-350=8 units; 1 -500= 12 units Call MD is boutaneously before meals abetes." abetes." abetes." and the MAR ration Record) revealed that m., Resident #103's blood her review of the MAR nt #103 received 12 units of There was no evidence that ade aware her blood sugar | {F 656 | The DON or designee will audit: 1 Residents with blood sugar param Residents catheters. Nursing administration will monito Residents with blood sugar param times a week for 4 weeks. 2. Mon orders for catheters and treatmen according to the orders and care µ Additional education and/or couns will be provided as indicated. Cor will be reported by the DON/Desig the quality assurance committee. Continued compliance will be mor though the facility s quality assur program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: August 31, 2018 | neters 2. rr 1. neters 5 itor new t record plan. seling ncerns gnee to nitored rance d | | |
| | - | d Sugar care plan dated | | | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM | : 09/04/2018 I APPROVED . 0938-0391 | |
|--------------------------|---|---|--------------------|--|---|----------|------------------------------------|---|--|
| STATEMENT C | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · <i>`</i> | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED R | | |
| | | 495109 | B. WING | | | | | < 08/2018 | |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | · · · | | | |
| | | | | 242 | 0 PEMBERTON RD | | | | |
| THE LAUR | ELS OF UNIVERSITY P | AKK | | RIC | HMOND, VA 23233 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | Ē | (X5) COMPLETION DATE | |
| {F 656} | fluctuation in blood su Guest will be free from from fluctuation blood status changes, treme weakness, appetite lo Interventions: "Admin orders. Observe for in effects. Report finding and document s/sx (s complications from flu Report abnormal find On 8/8/18 at 11:54 a. conducted with LPN (the nurse who worked 8/4/18. When asked meant, LPN #2 stated higher than 400, then be notified before give scale insulin. When a documented anywher the physician was not should be documented she was still new to d system and was still t (point click care). Wh notifying the physician Resident #103's blood stated she did not not she did not realize the to notify the physician gave the 12 units of s order. LPN #2 confirm followed. When asked plan, LPN #2 stated t guide of care for nurs | d the following: "At risk for ugars related to Diabetes. m signs of complications I sugars such as mental ors/shakiness, dizziness, oss thru next review date. ister medications per neffectiveness and side gs to physician. Observe igns/symptoms) of uctuating blood sugar. ings to physician." m., an interview was flicensed practical nurse) #2, d with Resident #103 on what the above order d that if the blood sugar was the medical doctor should ing the 12 units of sliding asked if it should be re in the clinical record that tified, LPN #2 stated, yes, it ed in a note. LPN #2 stated ocumenting in the computer rying to figure out PCC hen asked if she could recall n on 8/4/18 regarding d sugar of 500, LPN #2 tify the physician because e order directed nursing staff h. LPN #2 stated she only iliding scale insulin per hed the order was not d the purpose of the care he care plan served as a es to follow for each | {F 6 | 556} | DEFICIENCY) | | | | |
| | | ted that all nurses had an. When asked if the care | | | | | | | |

Facility ID: VA0249

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 |
|--------------------------|---|---|-------------------|-----|---|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 495109 | B. WING | | | | ™ /08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| {F 656} | When asked some rewould not be followed nurse was not paying When asked if Reside followed if the physici abnormal blood sugar confirmed that Reside followed. On 8/8/18 at 2:51 p.m member) #1, the adm (Director of Nursing), Transition Specialist, Director of Operations above concerns. ASM #3 stated that the policy on care plans. No further information According to Potter at Nursing, 7th Edition, p care plan communica other health care profiplan enhances the co specific nursing intervithe goals of care. The blueprint for nursing a for implementation of the care actions." | ed, LPN #2 that it should. asons why the care plan I, LPN #2 stated that if the attention to the care plan. ent #103's care plan was an was not notified of an r per order, LPN #2 ent #103's care plan was not n., ASM (administrative staff inistrator, ASM #2, the DON ASM #3, the Clinical and ASM #4, the Regional is was made aware of the the facility did not have a in was presented prior to exit. Ind Perry's, Fundamentals of page 269 states "A written tes nursing care priorities to fessionals. The nursing care intinuity of care by listing ventions needed to achieve the complete care plan is the action. It provides direction the plan plus the framework slient's response to nursing indicated to improve fults and children with is information was obtained | {F 6 | 356 | 5} | | |

Facility ID: VA0249

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| | | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 APPROVED 0. 0938-0391 |
|---|--|---|---------------------|---|--|-------------------|---|
| STATEMENT OF DEF AND PLAN OF CORR | ICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | _ | F 08/ | ≺ 08/2018 |
| NAME OF PROVIDE | ER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAURELS | OF UNIVERSITY PA | RK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| https: m?s 2. TI supr plan Resi 2/2/0 that sclea pres The quar refer havi inter was The from eatir inde Revi 2/9/1 infec (rela cath (mul mob (catt (med | etid=c8ecbd7a-0e he facility staff fail rapubic catheter p for Resident #100 ident #106 was ac 01 and readmitted included but were rosis (1), inability sure and arthritis. most recent MDS reaction of 4/2 ng scored a 15 ou view for mental st cognitively intact resident was code a staff for activities ng which the residen 18 documented, "I ction): At risk for L tet do) S/P (supra- eter due to neuros tiple sclerosis), hy ility. Interventions heter) care daily a dical doctor) order iew of the August umented, "Cleansp normal saline app night shift for sup | ih.gov/dailymed/drugInfo.cf e22-4fc7-a503-faa58c1b6f3f ed to provide care to the er the comprehensive care 5. dmitted to the facility on on 9/24/12 with diagnoses e not limited to: multiple to urinate, high blood e (minimum data set), a , with an ARD (assessment 8/18 coded the resident as it of 15 on the BIMS (brief ratus) indicating the resident to make daily decisions. ed as requiring assistance of daily living except for ent could perform t's care plan initiated on Need UTI (urinary tract Jrinary Tract Infection R/T apubic) [2] indwelling genic (3) bladder R/T MS c (history) UTI, limited . S/P (status/post) cath nd as needed per MD | {F 656} | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 09/04/2018 MAPPROVED). 0938-0391 |
|--------------------------|---|--|-------------------|------|--|--|-------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | | | २ 08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, | ZIP CODE | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | | 420 PEMBERTON RD CICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORRECTIV CROSS-REFERENCEI | N OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY) | | (X5) COMPLETION DATE |
| {F 656} | shift for maintenance. Change dressing arou use bacitracin (4) arou night shift for mainten 07/05/2018." Review of the August administration record around suprapubic sit bacitracin every even suprapubic catheter of Suprapubic Cath (cath maintenance. Start Da dressing around supra bacitracin (4) around shift for maintenance Each order was docut administered. An interview was comp.m. with RN (register manager. When aske plans, RN #1 stated, ' to how to direct their of someone (staff memb a snap shot of what's When asked who use stated, "The staff. The assistants, the doctor plans were to be follo An interview was comp.m. with LPN (license resident's nurse. Whe catheter order the sta "It gets done in the ev When asked if the cat on the day shift, LPN | Start Date. 05/09/2018. and suprapubic catheter, und site every evening and ance Start Date. 2018 treatment documented, "Cleanse e with normal saline apply ing and night shift for are. Start Date. 09/20/2017. heter) Care every shift for ate. 05/09/2018. Change apubic catheter, use site every evening and night Start Date. 07/05/2018." mented as being ducted on 8/8/18 at 12:55 red nurse) #1, the unit d why residents had care 'So we can refer to them as care and if we have ber) who is new it gives them going on with that resident. d the care plan, RN #1 | {F 6 | 556} | | | | |

Facility ID: VA0249

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 MAPPROVED). 0938-0391 |
|--------------------------|---|---|---------------------|--|--|-------------------|--|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | _ | | २ 08/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | | 5 | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | 420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 656} | have put refused and asked if the care plan #3 stated it was not. An interview was comp. m. with LPN #7, a u what was included in stated, "Cath [cathete around the site." On 8/8/18 at 2:50 p.m member) #1, the adm director of nursing, AS specialist and ASM #4 clinical operations we findings. A request for plans was requested On 8/8/18 at 4:20 p.m note that the care plan (resident assessment No further information According to Fundam Williams and Wilkins documented, "A writte communication tool a members that helps e careThe nursing cal information about the and goals. It contains achieving the goals es and is used to direct of | LPN #3 stated, "I should called the doctor." When was being followed, LPN ducted on 8/8/18 at 2:35 nit manager. When asked catheter care, LPN #7 r] care means we wipe a. ASM (administrative staff inistrator, ASM #2, the SM #3, the clinical transition 4, the regional director of re made aware of the r the facility's policy on care of ASM #1 at that time. a., ASM #3 returned with a ns were done per the RAI instrument) manual. a was provided prior to exit. entals of Nursing Lippincott 2007 pages 65-77 en care plan serves as a mong health care team | {F 656} | | | | |
| | with new orders" (1) | condition, treatments, and) | | | | | |

Facility ID: VA0249

If continuation sheet Page 18 of 70

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 APPROVED 0. 0938-0391 |
|--------------------------|--|--|---------------------|---------------------------------------|--|-------------------|---|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | F 08/ | ≺ 08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, STA | TE, ZIP CODE | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | 420 PEMBERTON RD ICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECT CROSS-REFERENC | PLAN OF CORRECTION FIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY) | | (X5) COMPLETION DATE |
| {F 656} | Continued From page (1) Fundamentals of N & Wilkins 2007 Lippin pages 65-77. Basic Nursing, Essen (Potter and Perry, 200 reference for care pla a written guideline for promoting continuity of criteria to be used in t care. The written care nursing care priorities professionals. The car coordinates resources care. A correctly form easy to continue care If the patient's status nursing diagnosis and no longer appropriate plan. An out of date of compromises the qua 1. Multiple sclerosis nervous system disea and spinal cord. It dan the material that surro nerve cells. This dam messages between y leading to the sympto was obtained from: https://medlineplus.go | e 18 Nursing Lippincott Williams cott Company Philadelphia tials for Practice, 6th edition, 07, pages 119-127), was a ns. "A nursing care plan is coordinating nursing care, of care and listing outcome the evaluation of nursing e plan communicates to other health care are plan also identifies and s used to deliver nursing hulated care plan makes it from one nurse to another. thas changed and the d related interventions are , modify the nursing care or incorrect care plan lity of nursing care." Multiple sclerosis (MS) is a ase that affects your brain mages the myelin sheath, bunds and protects your age slows down or blocks our brain and your body, ms of MS. This information | {F 656} | | | | |
| | (tube) drains urine fro inserted into your blac your belly. This inform | dder through a small hole in nation was obtained from: nedlineplus/275/ency/patienti | | | | | |

Facility ID: VA0249

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 09/04/20 FORM APPROVE OMB NO. 0938-039 |
|--------------------------|---|--|---------------------------------|--|---|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | | (X3) DATE SURVEY COMPLETED |
| | | 495109 | B. WING | | R 08/08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | • | STRI | EET ADDRESS, CITY, STATE, ZIP CC |)DE |
| THE LAUF | RELS OF UNIVERSITY P | ARK | |) PEMBERTON RD HMOND, VA 23233 | |
| (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 COMPLETION HE APPROPRIATE DATE |
| {F 656} F 657 SS=D | problem in which a p due to a brain, spinal This information was wwwqa.nlm.nih.gov/r 000754.htm 4. Bacitracin The a profound action again pathogens, including and Staphlococci. It i gram-negative organ obtained from: https://dailymed.nlm.i gXsl.cfm?setid=6ed2 a034de Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Compreh §483.21(b)(2) A comp be- (i) Developed within T the comprehensive a (ii) Prepared by an in includes but is not lim (A) The attending phy (B) A registered nursi- resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prac- the resident and the particular second the resident and the particular second if the | er Neurogenic bladder is a erson lacks bladder control cord, or nerve condition. obtained from: nedlineplus/275/ency/article/ ntibiotic, Bacitracin, exerts a nst many gram-positive the common Streptococci s also destructive for certain isms. This information was nih.gov/dailymed/fda/fdaDru f2bd-9d2f-46af-a44c-95a02c d Revision (i)-(iii) ensive Care Plans prehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that nited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined | {F 656} | | 8/31/18 |

Facility ID: VA0249

If continuation sheet Page 20 of 70

| STATEMENT (| OF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | (X3) DA1 | IO. 0938-039 TE SURVEY MPLETED |
|--------------------------|---|---|--------------------|-----|--|--|--------------------------------------|
| | | 495109 | B. WING | | | | R 8/08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | 0,00,2010 |
| | | | | 24 | 420 PEMBERTON RD | | |
| THE LAU | RELS OF UNIVERSITY P | ARK | | R | ICHMOND, VA 23233 | | |
| (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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 657 | resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and c assessments. This REQUIREMENT by: Based on observatio record review, it was failed to review and rev of 15 residents in the #105. | e staff or professionals in ined by the resident's needs he resident. rised by the interdisciplinary resement, including both the quarterly review T is not met as evidenced on, staff interview, and clinical determined that facility staff evise the care plan for one survey sample, Resident d to revise Resident #105's plan when her sectional | F | 657 | Ftag 657 Resident #105- No negative outcome occurred as a result of this practice Resident was assessed by therapy du the survey. She was assessed at no longer requiring the section plate. The care plan has been revised to reflect to change. | uring | |
| | 11/23/13 and readmit that included but wer hydrocephalus (1), ur blood pressure, cong stroke, and disorder of most recent MDS (mi assessment was a si assessment with an A date) of 7/7/18. Resid being moderately imp scoring 11 out of 15 of for mental status) exa coded as requiring ex staff member with be dressing, and person | dmitted to the facility on tted on 4/8/18 with diagnoses e not limited to nspecified convulsions, high enital spondylolisthesis (2), of the bone. Resident #105's inimum data set) | | | All residents have the potential to be affected by this practice The DON or designee will educate licensed staff on revising the care plat and following the plan of care for ada equipment needed with meals. The DON or designee will audit care p for current residents that require adapt equipment for meals. The DON or designee will monitor car plans for new orders for adaptive equipment 5 times a week for 4 week Additional education and/or counselin will be provided as indicated. Concer will be reported by the DON/Designee the quality assurance committee. | otive blans btive re s. g ns | |

Facility ID: VA0249

If continuation sheet Page 21 of 70

| | | ND HUMAN SERVICES MEDICAID SERVICES | | | | FORI | D: 09/04/2018 M APPROVED D. 0938-0391 |
|--------------------------|-------------------------------|---|--------------------|-----|---|-------------------|---|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED |
| | | 495109 | B. WING | | | | R / 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | · | • | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | RELS OF UNIVERSITY P | ADK | | 24 | 420 PEMBERTON RD | | |
| | | | | R | RICHMOND, VA 23233 | | |
| (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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 657 | Continued From page | e 21 | F | 657 | | | |
| | | staff member for meals. | | 007 | | | |
| | | | | | Continued compliance will be monitor | ed | |
| | | tional care plan dated 3/1/18 | | | though the facility as quality assurance | е | |
| | and revised on 7/30/ | | | | program. Additional education and | | |
| | R/T (related to) hx (h | nal and/or dehydration risk istory) CVA (cerebral | | | monitoring will be initiated for any identified concerns. | | |
| | | roke), HTN (hypertension | | | | | |
| | |), GERD (Gastrointestinal | | | Completion date: August 31, 2018 | | |
| | Reflux disease), obe | | | | | | |
| | Requires therapeutic | neals." This intervention was | | | | | |
| | initiated on 4/17/18. | | | | | | |
| | | | | | | | |
| | | n., an observation was made | | | | | |
| | | esident #105 was sitting up She had a sandwich and | | | | | |
| | | ate. Resident #105 did not | | | | | |
| | have a sectional plate | | | | | | |
| | | e Equipment: Sectional | | | | | |
| | | 5 was feeding herself her d not appear to have any | | | | | |
| | difficulties eating her | | | | | | |
| | On 9/9/19 at 9:52 a m | | | | | | |
| | | n., an observation was made sident #105 was sitting up | | | | | |
| | | sident #105 had eggs and | | | | | |
| | toast on the same pla | ate. Resident #105 did not | | | | | |
| | have a sectional plate | | | | | | |
| | | /e Equipment: Sectional /5 was feeding herself her | | | | | |
| | | d not appear to have any | | | | | |
| | difficulties eating her | | | | | | |
| | Review of Resident # | 105's August 2018 POS | | | | | |
| | (physician order sum | mary) failed to evidence an | | | | | |
| | - | plate. Review of her dietary | | | | | |
| | | nce an order for a sectional | | | | | |
| | plate. | | | | | | |
| | | | | | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | : 09/04/2018 APPROVED . 0938-0391 |
|--------------------------|---|--|---------------------|---------------------------------------|---|-------------------|---|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | F 08/0 | २ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, STAT | E, ZIP CODE | | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | 420 PEMBERTON RD ICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTI CROSS-REFERENCI | AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY) | | (X5) COMPLETION DATE |
| F 657 | notes failed to eviden orders for a sectional Further review of Res failed to evidence whe recommended and by On 8/8/18 at 12:42 p. conducted with OSM dietary manager. Wh was supposed to hav stated that she was si plate because it was of OSM #1 stated a diet required in order for the adaptive equipment. We #103 needed a section that he was not sure, the reason why a resi adaptive items. When the observation made stated the a new guy morning and must of When OSM #1 was in observations made the stated that he wasn't On 8/8/18 at 1:07 p.m conducted with LPN (the unit manager and intervention for the se #103's care plan. Wh was supposed to hav meals, LPN #7 stated | 105's clinical record a currently receiving The occupational therapy ce any recommendations or plate. ident #105's clinical record en the sectional plate was what department. m., an interview was (other staff member) #1, the en asked if Resident #103 e a sectional plate, OSM #1 upposed to have a sectional ordered on her meal ticket. ary order from nursing was he resident to get special When asked why Resident nal plate, OSM #1 stated that dietary was never told dent needed certain n OSM #1 was informed of e that morning, OSM #1 was doing tray line that missed the sectional plate. Iformed about the e previous night, OSM #1 sure why it was missed. a., an interview was licensed practical nurse) #7, the nurse who wrote the ectional plate on Resident en asked if Resident #103 e a sectional plate for that she did not know. nown Resident #103's care | F 657 | | | | |

Facility ID: VA0249

If continuation sheet Page 23 of 70

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 MAPPROVED). 0938-0391 |
|--------------------------|--|---|---------------------|---|--|-------------------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ° <i>î</i> | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | _ | | २ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAUI | RELS OF UNIVERSITY PA | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 657 | come from somewher have been recomment asked the purpose of stated that the purpose communicate residen all direct care staff ha When asked if the care LPN #7 stated that it st On 8/8/18 at 1:37 p.m conducted with OSM OSM #3 stated that the plate for some time. Of (occupational therapy Resident #103 in April sectional plate was not stated Resident #103 eating her meals and self feeding. OSM #3 intervention should not plan. On 8/8/18 at 2:51 p.m member) #1, the adm (Director of Nursing), Transition Specialist, Director of Operations above concerns. ASM #3 stated that the policy on care plans. presented prior to exit According to Fundarm Williams and Wilkins i | 47 stated, "It must have re." LPN #7 stated it may ided by therapy. When the care plan, LPN #7 se of the care plan was to t needs. LPN #7 stated that d access to the care plan. are plan should be accurate, should be accurate. an interview was #3, the Director of Therapy. are resident used a sectional thas not needed a sectional DSM #3 stated that OT) recently evaluated I for contractures, but that a bot recommended. OSM #3 did not have difficulties just needed set up help for stated the above of have been on her care ASM (administrative staff inistrator, ASM #2, the DON ASM #3, the Clinical and ASM #4, the Regional is was made aware of the are facility did not have a No further information was t. | F 65 | | | | |

Facility ID: VA0249

If continuation sheet Page 24 of 70

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 1 APPROVED). 0938-0391 |
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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | | | LETED |
| | | 495109 | B. WING | | _ | | २ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAUF | | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| | | ATEMENT OF DEFICIENCIES | | , | S PLAN OF CORRECTION | | 0(5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 657 | information about the and goals. It contains achieving the goals e and is used to direct of revise and update the there are changes in with new orders" (1) Hydrocephalus is cerebrospinal fluid in cushions your brain. It though, it puts harmfu Hydrocephalus can b birth. Causes include problems with how th unusually large head congenital hydroceph also happen after birt hydrocephalus. It can can include head inju tumors, and bleeding information was obtai Institutes of Health. https://medlineplus.go (2) Congenital spondy which one vertebrae a another, may result fr degenerative conditio present at birth (cong obtainted from The N https://www.ncbi.nlm. T0024994/. Services Provided Me | ensure continuity of re plan is a vital source of patient's problems, needs, a detailed instructions for stablished for the patient careexpect to review, e care plan regularly, when condition, treatments, and the buildup of too much the brain. Normally, this fluid When you have too much, al pressure on your brain. e congenital, or present at genetic problems and e fetus develops. An is the main sign of alus. Hydrocephalus can h. This is called acquired occur at any age. Causes ries, strokes, infections, in the brain. This ned from The National ov/hydrocephalus.html. ylolisthesis is a condition in slips forward on one om an accident, n or in rare cases, may be enital). This information was ational Institutes of Health. nih.gov/pubmedhealth/PMH | F 65 | 7 | | | 8/31/18 |
| SS=D | | | | | | | - |

Facility ID: VA0249

If continuation sheet Page 25 of 70

| CENTER | | ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPLE | CONSTRUCTION | | APPROVE 0.0938-039 SURVEY |
|--------------------------|-------------------------------|---|--------------------|-------------|---|------|---------------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | · , | A. BUILDING | | | LETED |
| | | 495109 | B. WING | | | | २ 08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | ST | FREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | RELS OF UNIVERSITY P | ARK | | 24 | 20 PEMBERTON RD | | |
| | | | | R | ICHMOND, VA 23233 | | |
| (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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 658} | Continued From page | e 25 | {F 6 | 581 | | | |
| (* • • • • • • • • | | ehensive Care Plans | ι (i C | ,007 | | | |
| | | d or arranged by the facility, | | | | | |
| | | mprehensive care plan, | | | | | |
| | must- | | | | | | |
| | (i) Meet professional | · · | | | | | |
| | by: | Γ is not met as evidenced | | | | | |
| | - | view, facility document review | | | Ftag 658 | | |
| | | view, it was determined that | | | | | |
| | - | to follow professional | | | Resident #106: No negative outcome | | |
| | | for two of 15 residents in | | | occurred from this practice. Catheter ca | are | |
| | the survey sample, R #108. | esident #106 and Resident | | | orders have been clarified with the | | |
| | #100. | | | | physician and is being provided to resident preference. | | |
| | 1. The facility staff fai | iled to clarify and accurately | | | | | |
| | - | oubic care as ordered by the | | | Resident# 108- No negative outcome | | |
| | physician for Resider | nt #106. | | | occurred from this practice. | | |
| | 2 The facility staff fai | iled to document the blood | | | Diabetic residents with blood sugar ord | ers | |
| | | the physician for Resident | | | and residents receiving catheter care | 0.0 | |
| | #108. | | | | have the potential to be affected. | | |
| | The findings include: | | | | The DON or designee will educate | | |
| | _ | | | | licensed nursing staff on accurate | | |
| | | s admitted to the facility on | | | documentation of catheter care and blo | od | |
| | | d on 9/24/12 with diagnoses | | | sugar readings. | | |
| | | e not limited to: multiple to urinate, high blood | | | DON or designee will audit MARs of | | |
| | pressure and arthritis | - | | | current diabetic residents with blood su | laar | |
| | | | | | orders and TARs of residents with | 5- | |
| | | S (minimum data set), a | | | catheter care orders for accurate | | |
| | | t, with an ARD (assessment | | | documentation. | | |
| | , | 28/18 coded the resident as | | | | | |
| | - | ut of 15 on the BIMS (brief status) indicating the resident | | | The DON or designee will monitor bloo | d | |
| | | t to make daily decisions. | | | sugar documentation for diabetic | u | |
| | | led as requiring assistance | | | residents with blood sugar orders 5 tim | es | |
| | from staff for activitie | s of daily living except for | | | a week for 4 weeks. Monitoring of new | | |
| | eating which the resid | dent could perform | | | catheter orders and documentation of | | |

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| TATEMENT (| OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATI | <u>0. 0938-039</u> E SURVEY PLETED | |
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| | | | | | | R | |
| | | 495109 | | | 08/08/2018 | | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD | | | |
| THE LAU | | ARK | | RICHMOND, VA 23233 | | | |
| (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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| {F 658} | 1 0 | e 26 | {F 658 | • | | | |
| | 2/9/18 documented, " infection): At risk for U (related to) S/P (supr catheter due to neuro (multiple sclerosis), h mobility. Interventions (catheter) care daily a (medical doctor) orde Review of the August documented, "Cleans with normal saline ap and night shift for sup Date. 09/20/2017. Su Care every shift for m 05/09/2018. Change catheter, use bacitrat | ogenic (3) bladder R/T MS x (history) UTI, limited s. S/P (status/post) cath and as needed per MD | | treatment provided will occur 5 ti week for 4 weeks. Additional edu and/or counseling will be provide indicated. Concerns will be repo the DON/Designee to the quality assurance committee. Continued compliance will be mo though the facility s quality assu program. Additional education ar monitoring will be initiated for any identified concerns. Completion Date: August 31, 2018 | ucation ed as rted by pnitored urance nd | | |
| | around suprapubic si bacitracin every even suprapubic catheter of Suprapubic Cath Car maintenance. Start D dressing around supr bacitracin (4) around shift for maintenance Each order was docu administered. | documented, "Cleanse te with normal saline apply ning and night shift for care. Start Date. 09/20/2017. The every shift for eate. 05/09/2018. Change rapubic catheter, use site every evening and night Start Date. 07/05/2018." | | | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOF | M APPROVED 0. 0938-0391 |
|--------------------------|---|--|-------------------|-----|---|----------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DAT | E SURVEY IPLETED |
| | | 495109 | B. WING | | | 0 | R 3/08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| {F 658} | catheter order the sta "It gets done in the ev When asked if the car on the day shift, LPN it." When asked why it done on the day shift, have put refused and asked why accurate of important, LPN #5 st done or not done." An interview was com p.m. with LPN #8. Wh resident's orders for st LPN #8 stated, "I wout why, LPN #8 stated, "I wout why, LPN #8 stated, "I itself." An interview was com p.m. with LPN #7, a ut to review the three diff orders for Resident # clarify the order." Whe documentation was d are many reasons. On are done. Communicat whoever else may ne When asked if it was document something wasn't, LPN #7 stated On 8/8/18 at 2:50 p.m member) #1, the adm director of nursing, As specialist and ASM # clinical operations we findings. A request for | ff followed, LPN #5 stated, vening and I think on nights." re was provided as ordered #5 stated, "No. He refuses it was documented as being , LPN #5 stated, "I should called the doctor." When documentation was ated, "To note it is being ducted on 8/8/18 at 2:05 nen asked to review the suprapubic catheter care, and clarify that." When asked 'Because it kinda contradicts ducted on 8/8/18 at 2:35 init manager. When asked fferent suprapubic catheter 106, LPN #7 stated, "I would en asked why one, LPN #7 stated, "There ne is so we know that things ate with the physicians or ed to know the information." acceptable for staff to as being done when it d, "Oh no, no, no." n. ASM (administrative staff inistrator, ASM #2, the SM #3, the clinical transition 4, the regional director of re made aware of the r the facility's policy on I for accurate documentation | {F 6 | 558 | } | | |

Facility ID: VA0249

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 // APPROVED). 0938-0391 |
|--------------------------|--|---|---------------------|-------------------------------|--|-------------------|--|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | _ | | २ 08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| | | | 24 | 420 PEMBERTON RD | | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | R | ICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 658} | Continued From page requested from ASM On 8/8/18 at 4:20 p.m stated the facility used procedures as their p Review of the facility's "OBSERVATIONS TO | #1 at that time. ASM #3 returned and d their policy and rofession standards. s policy titled, | {F 658} | | | | |
| | PHYSICIAN" did not a orders. There was no documentation. | address clarification of policy for accurate | | | | | |
| | According to Potter an Nursing, 7th edition, p following statements: competent nursing pr client and members o When you carry out a intervention, it is as m | a was provided prior to exit. And Perry's, Fundamentals of bage 268 documents the "Clarifying an order is actice, and it protects the f the health care team. In incorrect or inappropriate buch your error as the transcribed the original | | | | | |
| | Perry's Fundamentals (2005, p. 477): "Docu written or printed that proof for authorized p within a client medica nursing practice. Nur accurate, comprehene retrieve critical data, r track client outcomes standards of nursing p client record provides level of quality of care Potter and Perry (200 | practice. Information in the a detailed account of the e delivered to the clients." | | | | | |

Facility ID: VA0249

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 APPROVED 0. 0938-0391 |
|--------------------------|--|--|---------------------|---|--|-------------------|---|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | F 08/0 | ≺ 08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE | , ZIP CODE | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIV CROSS-REFERENCE | AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIA CIENCY) | | (X5) COMPLETION DATE |
| {F 658} | timely, effective mann 1. Multiple sclerosis nervous system disea and spinal cord. It dar the material that surro nerve cells. This dam messages between yu leading to the sympto was obtained from: https://medlineplus.go 2. Suprapubic cathete (tube) drains urine fro inserted into your blac your belly. This inform wwwqa.nlm.nih.gov/m nstructions/000145.ht 3. Neurogenic bladde problem in which a per due to a brain, spinal This information was wwwqa.nlm.nih.gov/m 000754.htm 4. Bacitracin The ar profound action again pathogens, including and Staphlococci. It is gram-negative organic obtained from: https://dailymed.nlm.r gXsl.cfm?setid=6ed2f a034de | ed to communicate nts accurately and in a her." • Multiple sclerosis (MS) is a lise that affects your brain mages the myelin sheath, bunds and protects your age slows down or blocks our brain and your body, ms of MS. This information • v/multiplesclerosis.html er A suprapubic catheter m your bladder. It is dder through a small hole in nation was obtained from: hedlineplus/275/ency/patienti m r Neurogenic bladder is a erson lacks bladder control cord, or nerve condition. obtained from: hedlineplus/275/ency/article/ htibiotic, Bacitracin, exerts a st many gram-positive the common Streptococci is also destructive for certain sms. This information was hih.gov/dailymed/fda/fdaDru i2bd-9d2f-46af-a44c-95a02c | {F 658} | | | | |
| | 2. The facility staff fail | ed to document the blood | | | | | |

Facility ID: VA0249

If continuation sheet Page 30 of 70

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | INTED: 09/04/2018 FORM APPROVED IB NO. 0938-0391 | |
|--------------------------|--|--|--|-----|---|-------------------------------|--|--|
| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
| | | 495109 | B. WING | | | R 08/08/2018 | | |
| NAME OF P | ROVIDER OR SUPPLIER | • | • | STF | REET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE LAU | RELS OF UNIVERSITY P | ARK | | | 0 PEMBERTON RD CHMOND, VA 23233 | | | |
| (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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| {F 658} | sugars as ordered by #108. Resident #108 was a 10/23/17 and readmit diagnoses that includ heart failure, diabetes disease and morbid of The most recent MDS significant change as (assessment reference the resident as having mental status) of 13 of resident was cognitive decisions. The resider assistance from staff living. Review of the resider 11/3/17 and revised of "Need At risk for fluct R/T (related to) Diabe labs (laboratory spec physician orders, rep physician. Start Date Review of the August documented, "Check meals and QHS (eve doctor) if over 400. S Review of the July 20 administration record "Check BS (blood sug (every night) notify M at 7:30 a.m. to 7/31/1 | the physician for Resident dmitted to the facility on ted on 4/9/18 with ed but were not limited to: s, high blood pressure, lung obesity. 6 (minimum data set), a sessment, with an ARD ce date) of 7/17/18 coded g a BIMS (brief interview for but of 15 indicating the ely intact to make daily ent was coded as requiring for all activities of daily nt's care plan initiated on on 8/7/18 documented, uation (sic) blood sugars etes. Interventions Obtain imens)/diagnostics per ort abnormal finding to 06/17/2018." 2018 physician orders BS (blood sugar) before ry night) notify MD (medical tart Date 06/18/2018." | {F 6 | 58} | | | | |

Facility ID: VA0249

If continuation sheet Page 31 of 70

| | | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 09/04/2018 // APPROVED). 0938-0391 |
|--------------------------|--|---|---------------|-----|--|----------|-------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | | | २ 08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | | 420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| | | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORF | PECTION | | (X5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (| (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BI | | COMPLETION DATE |
| {F 658} | Continued From page | 31 | {F 6 | 58} | | | | |
| | Review of the July 20 | 18 blood sugar summary | | | | | | |
| | form did not evidence | the blood sugar results for | | | | | | |
| | | 11:30 a.m. and bed time; | | | | | | |
| | 7:30 a.m. and 11:30 a.m. | and bedtime and 7/30/18 at | | | | | | |
| | | | | | | | | |
| | | notes from 7/28/18 through | | | | | | |
| | 7/30/18 did not evider regarding the blood s | | | | | | | |
| | | uyars. | | | | | | |
| | An interview was con | ducted on 8/8/18 at 12:55 | | | | | | |
| | | red nurse) #1, a nurse who | | | | | | |
| | | on 7/30/18. When asked to administration record for | | | | | | |
| | | ugars, RN #1 stated, "I | | | | | | |
| | | always do. There was no | | | | | | |
| | prompt (in the compu | • | | | | | | |
| | | sked why staff documented #1 stated, "So we can | | | | | | |
| | | o we can go back in our | | | | | | |
| | | 's been done." When asked | | | | | | |
| | - | ation was considered a | | | | | | |
| | professional standard | , RIN #1 SIdleu, yes. | | | | | | |
| | - | w another nurse who did not ugars was unsuccessful. | | | | | | |
| | | i. ASM (administrative staff inistrator, ASM #2, the | | | | | | |
| | director of nursing, AS | SM #3, the clinical transition | | | | | | |
| | | 4, the regional director of | | | | | | |
| | clinical operations we findings A request for | re made aware of the r the facility's policy on | | | | | | |
| | | for accurate documentation | | | | | | |
| | was requested from A | | | | | | | |
| | | ., ASM #3 returned and | | | | | | |
| | stated the facility use | a their policy and | | | | | | |

Facility ID: VA0249

If continuation sheet Page 32 of 70

| TATEMENT (| S FOR MEDICARE & | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPLE | | (X3) DATE | D. 0938-039 SURVEY |
|--------------------------|---|---|-------------------|-------|---|-----------|----------------------------|
| ND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | ING | | | PLETED |
| | | 495109 | B. WING | | | | R / 08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | RELS OF UNIVERSITY P | ARK | | 24 | 20 PEMBERTON RD | | |
| | | | | R | ICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 658} | Continued From page | a 32 | {F 6 | 581 | | | |
| (| | rofessional standards. No | יי | 1001 | | | |
| | policy was provided r documentation. | | | | | | |
| | No further information | n was provided prior to exit. | | | | | |
| {F 684} | Quality of Care | | {F 6 | 684} | | | 8/31/18 |
| SS=D | CFR(s): 483.25 | | | | | | |
| | § 483.25 Quality of c | are | | | | | |
| | - | indamental principle that | | | | | |
| | | nt and care provided to | | | | | |
| | | ed on the comprehensive dent, the facility must ensure | | | | | |
| | | e treatment and care in | | | | | |
| | | essional standards of | | | | | |
| | | nensive person-centered | | | | | |
| | care plan, and the re | sidents' choices. | | | | | |
| | | is not met as evidenced | | | | | |
| | by: | iou, focility document review. | | | | | |
| | | iew, facility document review view, the facility staff failed | | | Ftag 684 | | |
| | | eceived treatment and | | | Resident # 103: No negative outcome | | |
| | services in accordance | | | | occurred from this practice. The physicia | an | |
| | | and the comprehensive | | | was notified of the elevated blood sugar | | |
| | | 15 residents in the survey | | | reading. | | |
| | sample, Resident #10 | 03 108, and 110. | | | | | |
| | 1 The facility staff for | iled to notify the physician | | | Resident #108: No negative outcome occurred from this practice | | |
| | - | when Resident #103's blood | | | | | |
| | sugar was over 400 c | | | | Resident #110: No negative outcome | | |
| | | | | | occurred from this practice. | | |
| | 2. The facility staff fai | | | | | | |
| | | interventions as ordered by | | | All residents have the potential to be | | |
| | the physician for Res | ident #108. | | | affected. | | |
| | 3. The facility staff fai | | | | The DON or designee will educate | | |
| | | interventions as ordered by | | | licensed nursing staff on notifying the | | |
| | the physician for Res | | | | physician of blood sugar readings per th | ٦ė | 1 |

Facility ID: VA0249

If continuation sheet Page 33 of 70

| | | MEDICAID SERVICES | | | |
|--------------------------|--|---|---------------------|--|-------------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | (X3) DATE SURVEY COMPLETED |
| | | | | | R |
| | | 495109 | B. WING | | 08/08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | |
| (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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETIC |
| {F 684} | Continued From page | e 33 | {F 684 | } | |
| | | | | physician □s orders and documentat | tion of |
| | The findings include: | | | non-pharmacological interventions p administering pain medication. | |
| | 1. Resident #103 was | s admitted to the facility on | | | |
| | - | es that included but were not | | The DON or designee will audit MAR | |
| | | , difficulty swallowing, | | for current diabetic residents with blo | |
| 1 | | navioral disturbance, type scle weakness, Resident | | sugar parameters for compliance wir physician notification. The DON or | tn |
| | | IDS (minimum data set) | | designee will audit MARs for current | · . |
| | | uarterly assessment with an | | residents with PRN pain medication | |
| | - | ference date) of 6/13/18. | | ensure there is an order for | |
| | Resident #103 was c | oded as being moderately | | non-pharmacological interventions to | o be |
| | on the BIMS (brief int | function scoring 11 out of 15 terview for mental status) | | attempted prior to the administration pain medication. | ı of |
| | | was coded as requiring | | | |
| | | ADLS (activities of daily | | Nursing administration will monitor b sugar orders 5 times a week for 4 w | |
| | living). | | | for appropriate physician notification | |
| | Review of Resident # | 103's August 2018 physician | | Nursing administration will monitor | |
| | | mented the following orders: | | documentation of non-pharmacologi | ical |
| | - | preakfast, lunch, dinner at | | interventions as ordered 5 times a w | veek |
| | | ls and at bedtime. Notify MD | | for 4 weeks. Additional education an | |
| | (medical doctor) of B | S <70 or >400. | | counseling will be provided as indica | ated. |
| | Humples (1) Colution | 100 LINUT/NAL Inight and | | Concerns will be reported by the | 1900 |
| | ÷ · · | 100 UNIT/ML Inject per 200= 2 units; 201-250=4 | | DON/Designee to the quality assura committee. | Ince |
| | units; 251-300=6 unit | | | | |
| | | 01 -500= 12 units Call MD is | | Continued compliance will be monitor | ored |
| | | bcutaneously before meals | | though the facility s quality assuran | |
| | and at bedtime for dia | - | | program. Additional education and monitoring will be initiated for any | |
| | Review of Resident # | 103's August 2018 MAR | | identified concerns. | |
| | | ration Record) revealed that | | | |
| | | m., Resident #103's blood | | | |
| | - | her review of the MAR | | Completion date: | |
| | | nt #103 received 12 units of | | August 31, 2018 | |
| | ÷ · | There was no evidence that | | | |
| | the physician was ma reading on 8/4/18. | ade aware her blood sugar | | | |

Facility ID: VA0249

If continuation sheet Page 34 of 70

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 APPROVED 0. 0938-0391 |
|--------------------------|--|---|---------------------|-------------------------------|--|-------------------|---|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | _ | F 180 | ≺ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| | RELS OF UNIVERSITY PA | ARK | | 2420 PEMBERTON RD | | | |
| | | | | RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 684} | Continued From page | 34 | {F 684} | | | | |
| | - | 2018 nursing notes failed to sician was made aware that 500 on 8/4/18. | | | | | |
| | Resident #103's Bloo 12/20/17, documenter fluctuation in blood su Guest will be free fror from fluctuation blood status changes, trend weakness, appetite lo Interventions: "Admin orders. Observe for in effects. Report finding and document s/sx (s complications from flu Report abnormal findi On 8/8/18 at 11:54 a.r conducted with LPN (the nurse who worked 8/4/18. When asked meant, LPN #2 stated higher than 400, then be notified before givi scale insulin. When a documented anywher the physician was not should be documente she was still new to d | d Sugar care plan dated d the following: "At risk for igars related to Diabetes. n signs of complications sugars such as mental ors/shakiness, dizziness, the medications per neffectiveness and side gs to physician. Observe igns/symptoms) of ictuating blood sugar. ngs to physician." m., an interview was licensed practical nurse) #2, d with Resident #103 on what the above order that if the blood sugar was the medical doctor should ng the 12 units of sliding | | | | | |
| | (point click care). Wh notifying the physician Resident #103's blood stated she did not not she did not realize the to notify the physician | en asked if she could recall | | | | | |

Facility ID: VA0249

If continuation sheet Page 35 of 70

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|---|---------------------|-----|---|-------------------|----------------------------|
| STATEMENT | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 495109 | B. WING | | | | R 1 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | I | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 00 | |
| THE LAU | RELS OF UNIVERSITY P | ARK | | | 420 PEMBERTON RD RICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIZ TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| {F 684} | order. LPN #2 confirm followed. On 8/8/18 at 2:51 p.m member) #1, the adm (Director of Nursing), Transition Specialist, Director of Operations above concerns. ASM #3 stated that th policy regarding follow No further information | ned that the order was not n., ASM (administrative staff hinistrator, ASM #2, the DON ASM #3, the Clinical and ASM #4, the Regional s was made aware of the ne facility did not have a wing physician's orders. | {F 6 | 84} | | | |
| | human insulin analog glycemic control in ac diabetes mellitus. Th from The National Ins https://dailymed.nlm.r m?setid=c8ecbd7a-0 2. The facility staff fai non-pharmacological the physician for Res Resident #108 was a 10/23/17 and readmit diagnoses that includ heart failure, diabetes disease and morbid o The most recent MDS significant change as (assessment reference | dults and children with is information was obtained stitutes of Health. hih.gov/dailymed/drugInfo.cf e22-4fc7-a503-faa58c1b6f3f led to document the interventions as ordered by ident #108. dmitted to the facility on ted on 4/9/18 with ed but were not limited to: s, high blood pressure, lung | | | | | |

Facility ID: VA0249

If continuation sheet Page 36 of 70

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 09/04/2018 // APPROVED). 0938-0391 |
|--------------------------|---|---|-------------------|-----|---|--|-------------------|--|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · <i>`</i> | | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | | | २ 08/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STA | TE, ZIP CODE | - | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | IX | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY) | | (X5) COMPLETION DATE |
| {F 684} | resident was cognitive decisions. The reside assistance from staff living. Review of the compre- on 10/23/17 document no specific intervention of non-pharmacologic Review of the August documented, "Document interventions prior to a needed) medication for 07/24/2018. Morphine MG/ML (milligram per mouth every 4 hours at Review of the July 20 medication administration prior to administering medication for pain. St Morphine Sulfate (1) st (milligram per milliliter every 4 hours as need at 11:13 p.m., 7/30/18 12:44 a.m. it was doc received the morphine documented evidence non-pharmacological receiving the morphine Review of the nurse's 8/5/18 did not evidence | but of 15 indicating the ely intact to make daily int was coded as requiring for all activities of daily ehensive care plan initiated hted, "Pain risk." There was ons regarding documentation cal interventions. 2018 physician's orders ent non-pharmacological administering PRN (as or pain. Start Date - e Sulfate (1) Solution 20 milliliter) Give 0.25 ml by as needed for Pain" 18 and August 2018 ation records documented, macological interventions PRN (as needed) Start Date - 07/24/2018. Solution 20 MG/ML r) Give 0.25 ml by mouth ded for Pain" On 7/28/18 at 10:05 p.m. and 8/5/18 at umented the the resident e. There was no e that the resident had interventions prior to re. a notes from 7/28/18 through ce documentation regarding interventions. | {F | 684 | } | | | |
| | | ducted on 8/8/18 at 12:55 | | | | | | |

Facility ID: VA0249

If continuation sheet Page 37 of 70

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | RINTED: 09/04/2018 FORM APPROVED JB NO. 0938-0391 |
|--------------------------|---|--|---------------------|--------|--|-------------|---|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , , | | ISTRUCTION | | 3) DATE SURVEY COMPLETED |
| | | 495109 | B. WING | | | | R 08/08/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | 1 | | STREE | ET ADDRESS, CITY, STATE, ZIP COD | E | |
| THE LAUF | | ARK | | 2420 I | PEMBERTON RD | | |
| | | | | RICH | MOND, VA 23233 | | |
| (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) | I SHOULD BE | (X5) COMPLETION DATE |
| {F 684} | manager. When aske follows when a reside #1 stated, "The staffs repositioning, some m ask them to rate their would be documented would document it on administration record Resident #108's July non-pharmacological stated, there was not there should be docu physician, RN #1 staff An interview was com p.m. with LPN (licens When asked about th a resident complained ask them if it's (the patheter they tell you. Like say shoulder you may offi- massage it to see if it giving pain medicatio would be documented supposed to be." On 8/8/18 at 2:50 p.m member) #1, the adm director of nursing, As specialist and ASM # clinical operations we findings. A request for | red nurse) #1, the unit ed about the process staff ent complained of pain, RN should offer some non-medical treatment and pain." When asked if this d, RN #1 stated, "Yes. They the MAR (medication)." When asked to review and August MAR for the documentation, RN #1 hing there. When asked if mentation as ordered by the ted there should be. ducted on 8/8/18 at 1:35 ed practical nurse) #3. te process staff follows when d of pain, LPN #3 stated, "I ain) between one to ten and v it's (the pain) is in their er a warm compress or twould help first (prior to n)." When asked if this d, LPN #3 stated, "Yes. It's n. ASM (administrative staff hinistrator, ASM #2, the SM #3, the clinical transition 4, the regional director of ere made aware of the r the facility's policy on te clinical records was | {F 6 | 84} | | | |
| | | s policy titled, "PAIN CORD" documented, "Policy: nt Record will be used by | | | | | |

Facility ID: VA0249

If continuation sheet Page 38 of 70

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOF | CD: 09/04/2018 RM APPROVED IO: 0938-0391 |
|--------------------------|--|--|-------------------|-----|---|----------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DAT | R |
| | | 495109 | B. WING | | | 0 | R 8/08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | L | | : | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| {F 684} | nursing staff to docum medication and/or noi guests experiencing a chronic pain. Purpose Record will be used to of the current pain reg as needed to achieve If other non-pharmacy implemented, the inter the Non-Pharmacy co No further information 1. Morphine Sulfate "gold standard" for re- one of the most effect for the management. obtained from: www.ncbi.nlm.nih.gov 3. The facility staff fai non-pharmacological the physician for Resi Resident #110 was ar 12/21/17 with diagnos not limited to: pain, fa heartbeat and demen The resident's most re- change assessment, coded the resident as the BIMS indicating the impaired cognitively. requiring assistance for daily living. Review of the compresent | nent the effectiveness of n-pharmacy interventions for acute pain or exacerbation of e: The Pain Management o assess the effectiveness gimen, and to revise the plan e pain control. Procedure: 10 y interventions are ervention is documented in olumn." In was obtained prior to exit. - Morphine is considered the lieving pain and is currently tive drugs available clinically This information was //pmc/articles/PMC3158334/ led to document the interventions as ordered by ident #110. dmitted to the facility on ses that included but were ills, diabetes, irregular | {F 6 | 584 | } | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 MAPPROVED). 0938-0391 |
|--------------------------|---|--|-------------------|------|---|-------------------|--|
| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | | २ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | s | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 2 | 2420 PEMBERTON RD | | |
| | RELS OF UNIVERSITY PA | | | F | RICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 684} | (due to) dx (diagnosis was no specific interv documenting the non- interventions. Review of the August documented, "Docum interventions prior to a needed) medication for MG (milligrams) Give every 6 hours as need Review of the August administration record, non-pharmacological administering PRN m Tablet 325 MG (millig mouth every 6 hours 8/1/18 at 2:18 p.m., it Tylenol was given. Th documented evidence non-pharmacological Review of the 8/1/18 evidence documentat non-pharmacological Review of the 8/1/18 evidence documentat non-pharmacological An interview was com p.m. with RN (registed manager. When aske follows when a reside #1 stated, "The staff s repositioning, some n ask them to rate their would be documented would document it on administration record, | s) ofdiabetes" There rention regarding -pharmacological 2 2018 physician's orders nent non-pharmacological administering PRN (as or pain. Tylenol Tablet 325 2 tablet (sic) by mouth ded for pain." 2 2018 MAR (medication) documented, "Document interventions prior to edication for pain. Tylenol rams) Give 2 tablet (sic) by as needed for pain." On was documented that the nere was was no e that a intervention was attempted. nurse's notes did not tion regarding interventions. ducted on 8/8/18 at 12:55 red nurse) #1, the unit ed about the process staff ent complained of pain, RN | {F 6 | 684} | | | |
| | - | and August MAR for the documentation, RN #1 | | | | | |

Facility ID: VA0249

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| | | ND HUMAN SERVICES | | | | M APPROVE 0. 0938-039 | |
|--------------------------|---|--|---------------------|--|-------------------------------|---------------------------|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | (X3) DATE SURVEY COMPLETED | | |
| | | 495109 | B. WING | | R 08/08/2018 | | |
| NAME OF PF | ROVIDER OR SUPPLIER | | • | STREET ADDRESS, CITY, STATE, ZIP CO | | | |
| THE LAUR | ELS OF UNIVERSITY P | ARK | | 2420 PEMBERTON RD | | | |
| 04015 | | ATEMENT OF DEFICIENCIES | | RICHMOND, VA 23233 PROVIDER'S PLAN OF C | | (1/5) | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | N SHOULD BE E APPROPRIATE | (X5) COMPLETIO DATE | |
| {F 684} | Continued From page | e 40 | {F 684 | a | | | |
| (, | | hing there. When asked if | 1 004 | 1 | | | |
| | | mentation as ordered by the | | | | | |
| | An interview was con | ducted on 8/8/18 at 1:35 | | | | | |
| | • | ed practical nurse) #3, the | | | | | |
| | | red the Tylenol. When asked aff follows when a resident | | | | | |
| | • | PN #3 stated, "I ask them if | | | | | |
| | | n one to ten and they tell | | | | | |
| | | pain) is in their shoulder you | | | | | |
| | if it would help first (p | npress or massage it to see | | | | | |
| | medication)." When a | | | | | | |
| | | stated, "Yes. It's supposed | | | | | |
| | | o review the resident's MAR, | | | | | |
| | LPN #3 stated she di | d attempt interventions, but must not | | | | | |
| | | em. When asked if the | | | | | |
| | physician ordered the | e interventions to be | | | | | |
| | documented, should should. | they be, LPN #3 stated they | | | | | |
| | On 8/8/18 at 2:50 p.n | n. ASM (administrative staff | | | | | |
| | member) #1, the adm | ninistrator, ASM #2, the | | | | | |
| | | SM #3, the clinical transition | | | | | |
| | - | 4, the regional director of ere made aware of the | | | | | |
| | findings. | | | | | | |
| | No further information | n was provided prior to exit. | | | | | |
| {F 695} SS=D | Respiratory/Tracheos CFR(s): 483.25(i) | stomy Care and Suctioning | {F 695 | 3 | | 8/31/18 | |
| 33-D | | | | 1 | | | |
| 33-D | § 483.25(i) Respirato | | | | | | |
| 33-0 | tracheostomy care ar | ry care, including nd tracheal suctioning. ure that a resident who | | | | | |

Facility ID: VA0249

If continuation sheet Page 41 of 70

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , , | PLE CONSTRUCTION | | TE SURVEY MPLETED |
|--------------------------|---|---|---------------------|-------------------------------|---|----------------------------|
| | | | A. BUILDIN | IG | | R |
| | | 495109 | B. WING | | - 0 | 8/08/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA | TE, ZIP CODE | |
| | | APK | | 2420 PEMBERTON RD | | |
| | | | | RICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY) | (X5) COMPLETION DATE |
| {F 695} | Continued From page | e 41 | {F 69 | 95} | | |
| . , | | ctioning, is provided such | | | | |
| | | professional standards of | | | | |
| | | nensive person-centered | | | | |
| | | nts' goals and preferences, | | | | |
| | and 483.65 of this su | bpart. | | | | |
| | This REQUIREMENT | is not met as evidenced | | | | |
| | by: | | | | | |
| | | n, staff interview, facility | | Ftag 695 | | |
| | | d clinical record review, it | | Desident #404 No. | | |
| | | the facility staff failed to | | Resident #101- No i | - | |
| | | eatment and services for two survey sample, Resident | | had discontinued the | practice The physician | |
| | #101 and #114. | survey sample, resident | | The oxygen tubing v | | |
| | | | | properly stored. | | |
| | 1 a. The facility staff | failed to check oxygen | | | | |
| | - | wean the oxygen as ordered | | Resident #114: No I | onger resides in the | |
| | by the physician for F | Resident #101. | | facility, however dur | ring the survey | |
| | | | | process the tubing v | was replaced and | |
| | | failed to store the oxygen | | properly stored. | | |
| | tubing in a sanitary m | nanner for Resident #101. | | | | |
| | 4 T I 6 1111 | | | Residents receiving | | |
| | - | failed to administer the | | have the potential to | De affected. | |
| | oxygen at the rate or Resident #101. | dered by the physician for | | The DON or designed | ee will educato | |
| | | | | | iff on following oxygen | |
| | 2. The facility staff fai | iled to store oxygen tubing in | | orders including che | 0,00 | |
| | a sanitary manner for | | | | oxygen settings. DON | |
| | , | | | | icate licensed nursing | |
| | The findings include: | | | staff on storage of o | | |
| | - | | | sanitary manner. | | |
| | | as admitted to the facility on | | | | |
| | • | s that included but were not | | The DON or designed | | |
| | • | elvis, high blood pressure, | | residents with oxyge | | |
| | dementia and arthritis | 3. | | rounds will be comp | | |
| | The meet recent MD | 2 (minimum data ast) = 1.1 | | oxygen is at the cor | - | |
| | | S (minimum data set), a 14 | | oxygen tubing is sto | neu propeny. | |
| | uay assessment, With | n an ARD (assessment | | | | |
| | - | 22/16 coded the resident as | | Nursing administrati | ion will conduct rounds | |

Facility ID: VA0249

If continuation sheet Page 42 of 70

| STATEMENT | OF DEFICIENCIES | MEDICAID SERVICES | (X2) MULTIPI | LE CONSTRUCTION | OMB NO. 0938-0 |
|--------------------------|---|---|---------------------|---|----------------|
| | CORRECTION | IDENTIFICATION NUMBER: | · , | | COMPLETED |
| | | | | | R |
| | | 495109 | B. WING | | 08/08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| THE LAUF | RELS OF UNIVERSITY P | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE COMPLET |
| {F 695} | Continued From page | e 42 | {F 695 | 3 | |
| | | ental status) indicating the | | settings and the storage of respira | atory |
| | | y impaired cognitively. The | | equipment. MARs will be monitore | ed 5 |
| | | is requiring assistance from | | times a week for 4 weeks for oxyg | |
| | | of daily living except for | | saturation documentation as orde | |
| | | dent could perform after the resident was coded as | | Additional education and/or couns will be provided as indicated. Cor | - |
| | receiving oxygen the | | | will be reported by the DON/Desig | |
| | 0,0 | | | the quality assurance committee. | |
| | | nt's comprehensive care plan | | | |
| | | id not address the resident's | | | - '4I |
| | oxygen order. | | | Continued compliance will be mor though the facility s quality assur | |
| | An observation was r | nade on 8/8/18 at 8:47 a.m. | | program. Additional education and | |
| | | e resident was sitting in the | | monitoring will be initiated for any | |
| | | en tubing was lying on the | | identified concerns. | |
| | | the oxygen concentrator | | | |
| | was set at 2 and 3/4 | liters per minute. | | Completion Date: August 31, 20 | |
| | | made on 8/8/18 at 10:10 a.m. | | | |
| | | e resident was sitting in the | | | |
| | | lent was receiving oxygen soft plastic prongs that fit in | | | |
| | | (ygen) connected to the | | | |
| | | The oxygen flow rate on | | | |
| | | ator was set at 2 and 3/4 | | | |
| | liters per minute. | | | | |
| | Review of the August | 2018 physician orders | | | |
| | | e wean oxygen as toleratead | | | |
| | | s (saturations) > (greater | | | |
| | than) 92%. Start Date | e - 08/01/2018." | | | |
| | Review of the August | 2018 treatment | | | |
| | | (TAR) documented, "Please | | | |
| | | aturations) TID (three times | | | |
| | a day), PRN (as need | ded) and with activity, Three | | | |
| | | (sic) oxygen for 5 days." | | | |
| | The boxes for 8/1/18 8/2/18 at 8:00 a.m. w | at 4:00 p.m., 8:00 p.m. and | | | |

Facility ID: VA0249

If continuation sheet Page 43 of 70

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE COMF | E SURVEY PLETED |
| | | 495109 | B. WING | | | | R / 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| {F 695} | 4:00 p.m. through 8/6 nurses' initials in the f result. Review of the August summary record failer oxygen saturation lev 4:00 p.m., 8:00 p.m.; p.m.; 8/3/18 at 4:00 p 4 p.m. and 8:00 p.m., 8:00 p.m. and 8/7/18 Further review of the documented: "08/01/2 (oxygen saturation lev Cannula); 08/04/2018 via Nasal Cannula); 0 % (Oxygen via Nasal (a.m.) 93 % (Oxygen Review of the nurses' did not evidence docu oxygen saturations. An interview was com p.m. of LPN (licensed resident's nurse. Whe staff follows when a re stated, "We check the the patient." When ask ordered for Resident liters." When asked w oxygen saturation for stated, "I checked it th the resident had oxyg she did." When asked order for weaning the "This is my first day w | 2018 oxygen saturation 2018 oxygen saturation 2018 oxygen saturation d to evidence that the el was obtained on 8/1/18 at 8/2/18 at 8:00 a.m., 8:00 .m. and 8:00 p.m.; 8/5/18 at 8/6/18 at 4:00 p.m. and at 4:00 p.m. and 8:00 p.m. summary record 2018 10:23 (a.m.) 97 % vel) (Oxygen via Nasal 3 10:48 (a.m.) 93 % (Oxygen 08/06/2018 09:44 (a.m.) 99 Cannula); 08/08/2018 09:59 via nasal Cannula)." r notes for Resident #101, umentation regarding the ducted on 8/8/18 at 1:35 I practical nurse) #3, the en asked about the process esident has oxygen, LPN #3 e oxygen rate when we see esked how much oxygen was #101, LPN #3 stated, "Two | {F 6 | 595 | | | |

Facility ID: VA0249

If continuation sheet Page 44 of 70

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 1 APPROVED 0. 0938-0391 |
|--------------------------|--|--|--------------------------------|--|--|-------------------|---|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING _ | | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | _ | F 08/0 | ≺ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | 420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 695} | oxygen saturation, LF When asked if the res wearing oxygen if the #3 stated, "I took it of saturation." When the was shared with LPN have gone back in an was asked to review f summary form. When that the nasal cannula was wearing oxygen, When asked if the res have the oxygen on, I An interview was com p.m. with LPN #8. LP the August 2018 treat for the oxygen satura blank boxes meant, L documented, it's not of staff had followed the stated they were not. review the resident's and the oxygen summ the staff were followin wean off the oxygen, are greater than 92 (p A telephone interview 2:12 p.m. with LPN #9 When asked if the do was on when the satu correct, LPN #9 state room air." When asked to wean off the oxygen have to look that up." | PN #3 stated, "It was 93." sident was supposed to be e saturation was 93 %, LPN if her when I got the e observation at 10:10 a.m. #3, LPN #3 stated, "I must ad taken it off later." LPN #3 the oxygen saturation a asked if the documentation a was on meant the resident LPN #3 stated yes it did. sident was supposed to LPN #3 stated she was not. ducted on 8/8/18 at 2:04 N #8 was asked to review tment administration record tions. When asked what the PN #8 stated, "It's not done." When asked if the physician's order, LPN #8 LPN #8 was asked to order to wean off the oxygen mary form. When asked if ng the physician's order to LPN #8 stated, "No. They percent)." was conducted on 8/8/18 at 9, the resident's nurse. cumentation that the oxygen uration was checked was d, "Yes or I would have put ed about the resident's order en, LPN #9 stated, "I would When asked if she knew e weaned off the oxygen, | {F 695} | | | | |

Facility ID: VA0249

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 MAPPROVED). 0938-0391 |
|--------------------------|---|--|---------------------|---|---|-------------------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | - | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | | २ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, S | TATE, ZIP CODE | • | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE | S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 695} | On 8/8/18 at 2:50 p.m member) #1, the adm director of nursing, AS specialist and ASM #4 clinical operations we findings. A request for oxygen therapy was r No policy was receive No further information 1 b. The facility staff f tubing in a sanitary m An observation was n of Resident #101's ro the room, the nasal ca oxygen concentrator. observed. An observation was n of Resident #101. The wheelchair. The nasa the oxygen concentra tank on the back of th nasal cannula was for cannula was uncover An observation was n of Resident #101. The wheelchair. The nasa the bed uncovered. T attached to the oxyge and remained uncover An observation was n of Resident #101 was the resident #101 was the resident was wea | ASM (administrative staff inistrator, ASM #2, the SM #3, the clinical transition 4, the regional director of re made aware of the r the facility's policy on made to ASM #1 at that time. an was obtained prior to exit. ailed to store the oxygen anner for Resident #101. ande on 8/7/18 at 12:55 p.m. om. The resident was not in annula was draped over the There was no plastic bag bade on 8/7/18 at 5:14 p.m. bade on 8/7/18 at 5:14 p.m. cannula was draped over the I cannula was draped over tor. There was an oxygen e resident's wheelchair; the ded up next to the tank. The ed. bade on 8/8/18 at 8:47 a.m. cannula was lying across he nasal cannula was in tank on the wheelchair | {F 695 | 5} | | | |

Facility ID: VA0249

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 MAPPROVED). 0938-0391 |
|--------------------------|--|---|---------------------|---|--|-------------------|--|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | _ | | २ 08/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | TATE, ZIP CODE | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE) CROSS-REFEREI | S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 695} | on the wheelchair rem An observation was m of Resident #101 with nurse. The resident w nasal cannula was lyi the room without pick the floor. An interview was comp.m. with RN (register manager. When aske was to be stored whe "In a bag." When aske doesn't get dirty. Keep what staff would do if the floor, RN #1 state An interview was comp.m. with LPN #3. Wh cannula was to be stor #3 stated, "We have t baggie." When asked the oxygen tank was f "It's supposed to be in asked where the resid the observation at 12: think it was on the bea observed on the floor, of it." On 8/8/18 at 2:50 p.m member) #1, the adm director of nursing, As specialist and ASM #4 clinical operations we | ached to the oxygen tank hained uncovered. ade on 8/8/18 at 12:48 p.m. a LPN #3, the resident's vas not in the room. The ng on the floor. LPN #3 left ing the nasal cannula up off ducted on 8/8/18 at 12:55 red nurse) #1, a unit d how the nasal cannula n not in use, LPN #3 stated, ed why, RN #1 stated, "So it ps it cleaner." When asked the nasal cannula was on d, "You need to change it." ducted on 8/8/18 at 1:35 hen asked how the nasal bred when not in use, LPN o put the tubing in a little how the nasal cannula on to be stored, LPN #3 stated, n a little baggie too." When dent's oxygen was during #48 p.m., LPN #3 stated, "I d." When informed it was , LPN #3 stated, "I'll get rid h. ASM (administrative staff inistrator, ASM #2, the SM #3, the clinical transition 4, the regional director of | {F 695] | | | | |
| | findings. | | | | | | |

Facility ID: VA0249

If continuation sheet Page 47 of 70

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 APPROVED 0. 0938-0391 |
|--------------------------|--|--|---------------------|--|--|-------------------|---|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | _ | F 08/ | ≺ 08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | 420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 695} | 1 c. The facility staff for oxygen at the rate or of Resident #101. An observation was m of Resident #101. The wheelchair. The resid via a nasal cannula (st the nose to deliver ox oxygen concentrator. the oxygen concentrator. When asked what rator was prescribed, LPN asked what the oxygen stated, "It's two and a adjusted the flow rate Review of the August documented, "Oxygen minute) via nasal can shift for sob (shortness 07/08/2018. D/C (disc Please wean oxygen (oxygen) sats (saturation coxygen sats (saturation oxygen sats (saturation) | a was obtained prior to exit. ailed to administer the dered by the physician for hade on 8/8/18 at 10:10 a.m. e resident was sitting in the ent was receiving oxygen soft plastic prongs that fit in ygen) connected to the The oxygen flow rate on tor was set at 2 and 3/4 hade on 8/8/18 at 12:48 p.m. LPN #3. The resident was xygen concentrator was on. e of oxygen Resident #101 #3 stated, "Two." When en was set at, LPN #3 half." LPN #3 immediately to two liters. 2018 physician orders n at 2 lpm (two liters per ula (sic) continuously every as of breath) Start Date - continue) Date - 08/01/2018. as toleratead (sic), o2 tions) > (greater than) 92%. 18." | {F 695} | | | | |
| | day for wean (sic) oxy | - | | | | | |

Facility ID: VA0249

If continuation sheet Page 48 of 70

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 MAPPROVED). 0938-0391 |
|--------------------------|---|---|--------------------------------|---------------------------------------|--|-------------------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING _ | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | _ | | २ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | 420 PEMBERTON RD ICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 695} | p.m. with RN #1, a un how often staff check stated, "I would think time they go in there." An interview was com p.m., with LPN #3. W checked the oxygen f concentrators, LPN # it once a shift." When Resident #101's oxyg not have a response. An interview was com p.m., with LPN #7, a u to review the physicia #101's oxygen and th LPN #7 stated, "I wou I don't know what oxy When asked how staf rate, LPN #7 stated, " and the ball should be On 8/8/18 at 2:50 p.m member) #1, the adm director of nursing, AS specialist and ASM #4 clinical operations we findings. A request for operating instructions oxygen was made at Review of the facility's Concentrators" docum concentrator will be u oxygen cylinder (in no | ducted on 8/8/18 at 12:55 hit manager. When asked the oxygen flow rate, RN #1 they would check it every " ducted on 8/8/18 at 1:35 hen asked how often staff low rate on the 3 stated, "We usually check asked if she had checked then rate that day, LPN #3 did ducted on 8/8/18 at 2:35 unit manager. When asked in's orders for Resident e weaning of the oxygen, ild clarify the order because gen level they were on." if checked the oxygen flow 'You check it at eye level e in the middle of the line." h. ASM (administrative staff inistrator, ASM #2, the SM #3, the clinical transition 4, the regional director of re made aware of the r the manufacturer's and facility policy for that time to ASM #1. s policy titled, "Oxygen mented, Policy: The oxygen | {F 695} | | | | |

Facility ID: VA0249

If continuation sheet Page 49 of 70

| | MENT OF HEALTH AN S FOR MEDICARE & I | D HUMAN SERVICES | | | | FORM | 2: 09/04/2018 1 APPROVED 2: 0938-0391 |
|--------------------------|--|---|--------------------------------|--|--|-------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING _ | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | _ | | २ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | 420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE) CROSS-REFEREI | PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 695} | 2.5, 3.0 3.5) prescribe Flow should be check with flow meter." No further information 2. The facility staff fail a sanitary manner for Resident #114 was ac 6/25/18 with diagnose limited to unspecified vitamin D deficiency, blood pressure, and E hyperplasia) (enlarge most recent MDS (min assessment was a 14 with an ARD (assessing 7/9/18. Resident #112 cognitively intact in th decisions scoring 15 of BIMS (brief interview Resident #114 was contreatments, procedure receiving respiratory se Review of Resident # (physician order summorder: "Oxygen 2 L (lift continuous every shift above 90 % (percent) On 8/8/18 at 10:35 a.1 made of Resident #111 his room. His oxygen his oxygen concentration | the gauge should be lle of the number line (2.0, ed by the physician. 3. Liter red by being (sic) eye level a was provided prior to exit. The do store oxygen tubing in Resident #114. dmitted to the facility on es that included but were not fracture of the left tibia, respiratory failure, high BPH (benign prostatic d prostate). Resident #114's nimum data set) • day scheduled assessment ment reference date) of 4 as coded as being e ability to make daily but of possible 15 on the for mental Status) exam. oded in Section 0 (Special es and programs) as services. 114's August 2018 POS mary) revealed the following ters) via nasal cannula t. Keep 02 sats (saturation) ." | {F 695} | | | | |

Facility ID: VA0249

If continuation sheet Page 50 of 70

| CATION NUMBER: | ` ´ | E CONSTRUCTION | | <u> 2. 0938-0391</u> |
|--|---|---|---|---|
| | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
| 495109 | B. WING | | | R / 08/2018 |
| | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| | | | | |
| | I | RICHMOND, VA 23233 | | |
| ECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOL | DBE | (X5) COMPLETION DATE |
| | {F 695] | } | | |
| esident #114's king Resident served picking . CNA #1 then blaced it in the n the oxygen view was asked how when not in use, g should be ked why tubing . CNA #1 stated find oxygen d that she would from the nurse. o place oxygen r, back in the ne tubing should bag. When la's oxygen er it was found she did not place #1 was informed at 10:49 a.m., wit away?" CNA placing Resident plastic bag after ew was urse) #1, a unit en tubing should 1 stated that | | | | |
| | 495109 DEFICIENCIES ECEDED BY FULL NG INFORMATION) ertified nursing esident #114's king Resident served picking to CNA #1 then blaced it in the n the oxygen view was asked how when not in use, g should be ked why tubing , CNA #1 stated hs. When asked find oxygen d that she would from the nurse. o place oxygen r, back in the he tubing should bag. When 14's oxygen er it was found she did not place #1 was informed at 10:49 a.m., bw it away?" CNA placing Resident plastic bag after | DEFICIENCIES ID PREFIX PREFIX NG INFORMATION) PREFIX TAG {F 695] ertified nursing esident esident #114's king Resident served picking CNA #1 then blaced it in the n n the oxygen view was asked how when not in use, g should be ked why tubing , CNA #1 stated is. When asked find oxygen d that she would from the nurse. o place oxygen r, back in the he tubing should bag. When l4's oxygen er it was found she did not place #1 was informed at 10:49 a.m., pw it away?" CNA placing Resident placing Resident plastic bag after iew was urse) #1, a unit iew was urse) #1, a unit ien tubing should 1 stated that itstated that | STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233 PEFICIENCIES ECEDED BY FULL NG INFORMATION) RIFORMATION) RIFORMATION) RIFORMATION) FREETX TAG PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRO DEFICIENCY) (F 695) PREFIX RIFORMATION) (F 695) PREFIX RIFORMATION) (F 695) PREFIX RIFORMATION) (F 695) PREFIX RIFORMATION) (F 695) PREFIX (F 695) (F 695) PREFIX (F 695) PREFIX (F 695) PREFIX (F 695) PREFIX (F 695) (F 695) PREFIX (F 695) (F | STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233 DEFICIENCIES ECEIDED BY FULL NG INFORMATION) PREFIX TAG PREFIX TAG PREFIX TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 695) ertified nursing esident #114's king Resident served picking . CNA #1 then placed it in the n the oxygen view was asked how when not in use, g should be ted why tubing . CNA #1 stated is. When asked find oxygen o place oxygen r, back in the he tubing should bag. When 14's oxygen er it was found she did not place #1 vas informed at 10:49 a.m., wit away?" CNA placing Resident placing Resident placing Resident placing Resident placing Resident placing Resident placing Resident placing Resident plastic bag after iew was urse) #1, a unit ten tubing should t stated that |

Facility ID: VA0249

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 09/04/20 FORM APPROVI OMB NO. 0938-03 |
|--------------------------|---|---|---------------------------------|--|--|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | | (X3) DATE SURVEY COMPLETED |
| | | 495109 | B. WING | | R 08/08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | STR | EET ADDRESS, CITY, STATE, ZIP C | |
| THE LAUF | RELS OF UNIVERSITY P | ARK | | PEMBERTON RD | |
| | | | I | HMOND, VA 23233 | |
| (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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC | ION SHOULD BE COMPLETIO HE APPROPRIATE DATE |
| {F 695} | Continued From page | e 51 | {F 695} | | |
| | to prevent contamina | tion. When asked what | | | |
| | - | gen tubing is found on the | | | |
| | | nat the tubing should be ed that oxygen tubing found | | | |
| | | ever be placed back in the | | | |
| | plastic storage bag. | | | | |
| | member) #1, the adm (Director of Nursing), Transition Specialist, | n., ASM (administrative staff hinistrator, ASM #2, the DON ASM #3, the Clinical and ASM #4, the Regional | | | |
| | Director of Operation above concerns. | s was made aware of the | | | |
| | | n was presented prior to exit. provided regarding the | | | |
| {F 842} SS=D | Resident Records - Io CFR(s): 483.20(f)(5), | dentifiable Information 483.70(i)(1)-(5) | {F 842} | | 8/31/18 |
| | (i) A facility may not r resident-identifiable t (ii) The facility may re resident-identifiable t accordance with a co agrees not to use or | elease information that is | | | |
| | professional standard | ecords. rdance with accepted ds and practices, the facility al records on each resident | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 APPROVED 0. 0938-0391 |
|--------------------------|--|--|---------------------|--|--|------|---|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | | | LETED |
| | | 495109 | B. WING | | _ | | २ 08/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | | S | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | 420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 842} | Continued From page (iv) Systematically org §483.70(i)(2) The faci | | {F 842} | | | | |
| | regardless of the form records, except when (i) To the individual, o | | | | | | |
| | (ii) Required by Law;(iii) For treatment, pay | yment, or health care ted by and in compliance | | | | | |
| | neglect, or domestic v activities, judicial and law enforcement purp purposes, research purp medical examiners, fu | urposes, or to coroners, uneral directors, and to avert | | | | | |
| | | alth or safety as permitted with 45 CFR 164.512. | | | | | |
| | | lity must safeguard medical ainst loss, destruction, or | | | | | |
| | for- | records must be retained required by State law; or | | | | | |
| | (ii) Five years from the there is no requirement | e date of discharge when nt in State law; or ars after a resident reaches | | | | | |
| | (i) Sufficient information (ii) A record of the res | dical record must contain- on to identify the resident; ident's assessments; ve plan of care and services | | | | | |

Facility ID: VA0249

If continuation sheet Page 53 of 70

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391 |
|--------------------------|--|--|---------------------|--|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495109 | B. WING | | R 08/08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| | | | 2 | 2420 PEMBERTON RD | |
| THE LAUP | RELS OF UNIVERSITY P | AKK | F | RICHMOND, VA 23233 | |
| (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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION |
| {F 842} | | / preadmission screening | {F 842} | | |
| | professional's progree (vi) Laboratory, radiol services reports as re This REQUIREMENT by: Based on staff interv and clinical record rev facility staff failed to n accurate clinical reco the survey sample, R #110. 1. The facility staff fai non-pharmacological the physician for Res 2. The facility staff fai non-pharmacological the physician for Res The findings include: 1. Resident #108 was 10/23/17 and readmit | acted by the State; acted by the State; and other licensed ass notes; and agy and other diagnostic aguired under §483.50. is not met as evidenced iew, facility document review view, it was determined naintain a complete and rd for two of 15 residents in esident #108 and Resident Ied to document the interventions as ordered by ident #108. Ied to document the interventions as ordered by ident #108. admitted to the facility on | | F842 Resident #108: No negative outcor occurred from this practice Resident # 110: No negative outcor occurred from this practice. Residents receiving PRN pain medi have the potential to be affected. The DON or designee will educate licensed nursing staff on documenta non-pharmacological interventions administering pain medication per physician order. The DON or designee will audit MA current residents with PRN pain medication to ensure there is an ord | me ication ation of prior to |
| | heart failure, diabetes disease and morbid of The most recent MDS significant change as (assessment reference the resident as having mental status) of 13 of resident was cognitive | s, high blood pressure, lung | | non-pharmacological interventions attempted prior to the administration pain medication. Nursing administration will monitor documentation of non-pharmacolog interventions as ordered 5 times a v for 4 weeks. Additional education a counseling will be provided as indic Concerns will be reported by the | to be n of gical week nd/or |

Facility ID: VA0249

If continuation sheet Page 54 of 70

| | | | | | TRUCTION | | 3 NO. 0938-03 |
|--|--|--|----------------------------|---|--|------------|---------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP A. BUILDING | | | · · · | DATE SURVEY COMPLETED |
| | | | | , <u> </u> | | | R |
| | | 495109 | B. WING | | | 08/08/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET | ADDRESS, CITY, STATE, ZIP CODE | • | |
| TUE 1 AU | | ADIZ | 2420 PEMBERTON RD | | | | |
| | RELS OF UNIVERSITY P | AKN | | RICHM | OND, VA 23233 | | |
| (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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETIO DATE |
| {F 842} | Continued From page 54 | | {F 842 | 2} | | | |
| | | ssistance from staff for all activities of daily ving. | | DO | N/Designee to the quality assur nmittee. | ance | |
|) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Review of the compre on 10/23/17 documer no specific intervention of non-pharmacologic | | thou prog moi | ntinued compliance will be moni ugh the facility⊡s quality assura gram. Additional education and nitoring will be initiated for any ntified concerns. | | | |
| | Review of the August documented, "Docum interventions prior to needed) medication f 07/24/2018. Morphine MG/ML (milligram pe mouth every 4 hours | | | mpletion date: gust 31, 2018 | | | |
| | Review of the July 2018 and August 2018 medication administration records documented, "Document non-pharmacological interventions prior to administering PRN (as needed) medication for pain. Start Date - 07/24/2018. Morphine Sulfate (1) Solution 20 MG/ML (milligram per milliliter) Give 0.25 ml by mouth every 4 hours as needed for Pain" On 7/28/18 at 11:13 p.m., 7/30/18 at 10:05 p.m. and 8/5/18 at 12:44 a.m. it was documented the the resident received the morphine. There was no documented evidence that the resident had non-pharmacological interventions prior to receiving the morphine. | | | | | | |
| | | s notes from 7/28/18 through ce documentation regarding interventions. | | | | | |
| | p.m. with RN (registe manager. When aske | ducted on 8/8/18 at 12:55 red nurse) #1, the unit ed about the process staff ent complained of pain, RN | | | | | |

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| | S FOR MEDICARE & | | | | | O. 0938-039 | |
|--------------------------|--|---|---------------------|---|------------|----------------------------|--|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | · · · · | E SURVEY IPLETED | |
| | | | A. BUILDING | | | R | |
| | | 495109 | B. WING | | 08/08/2018 | | |
| NAME OF P | ROVIDER OR SUPPLIER | I | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE LAU | RELS OF UNIVERSITY P | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| {F 842} | #1 stated, "The staff s repositioning, some n ask them to rate their would be documented would document it on administration record Resident #108's July non-pharmacological stated, there was not An interview was com p.m. with LPN (licens When asked about th a resident complained ask them if it's (the patheter they tell you. Like say shoulder you may offi- massage it to see if it giving pain medication would be documented supposed to be." On 8/8/18 at 2:50 p.m member) #1, the admin director of nursing, Asspecialist and ASM # clinical operations we findings. A request for complete and accurar requested at from AS Review of the facility' MANAGEMENT REC The Pain Managemenursing staff to docur medication and/or no | should offer some non-medical treatment and pain." When asked if this d, RN #1 stated, "Yes. They the MAR (medication)." When asked to review and August MAR for the documentation, RN #1 hing there. ducted on 8/8/18 at 1:35 ed practical nurse) #3. the process staff follows when d of pain, LPN #3 stated, "I ain) between one to ten and v it's (the pain) is in their er a warm compress or twould help first (prior to n)." When asked if this d, LPN #3 stated, "Yes. It's the ASM (administrative staff hinistrator, ASM #2, the SM #3, the clinical transition 4, the regional director of ere made aware of the r the facility's policy on te clinical records was M #1 at that time. s policy titled, "PAIN CORD" documented, "Policy: nt Record will be used by nent the effectiveness of n-pharmacy interventions for acute pain or exacerbation of | {F 842 | | | | |

Facility ID: VA0249

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|---|--------------------|------|---|------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | E CONSTRUCTION | | LETED |
| | | 495109 | B. WING | | | | २ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | · | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 842} | of the current pain reg as needed to achieve If other non-pharmacy implemented, the inter the Non-Pharmacy co No further information 1. Morphine Sulfate "gold standard" for re one of the most effect for the management. obtained from: www.ncbi.nlm.nih.gov 2. The facility staff fai non-pharmacological the physician for Rest Resident #110 was an 12/21/17 with diagnos not limited to: pain, fa heartbeat and demen The resident's most re change assessment, coded the resident as the BIMS indicating the impaired cognitively. Review of the compre- on 12/21/17 document | gimen, and to revise the plan pain control. Procedure: 10 y interventions are revention is documented in olumn." In was obtained prior to exit. Morphine is considered the lieving pain and is currently tive drugs available clinically This information was //pmc/articles/PMC3158334/ led to document the interventions as ordered by ident #110. dmitted to the facility on ses that included but were lls, diabetes, irregular tia. ecent MDS, a significant with an ARD of 7/7/18 a having a six out of 15 on he resident was severely The resident was coded as from staff for all activities of ehensive care plan initiated hted, "Potential for pain d/t s) ofdiabetes" There ention regarding | (F 8 | 342} | | | |

Facility ID: VA0249

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 09/04/2018 MAPPROVED). 0938-0391 |
|--------------------------|---|--|-------------------|------|---|--|-------------------|--|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | - | | २ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 842} | Review of the August documented, "Docum interventions prior to needed) medication for MG (milligrams) Give every 6 hours as need Review of the August administration record non-pharmacological administering PRN m Tablet 325 MG (millig mouth every 6 hours 8/1/18 at 2:18 p.m., it Tylenol was given. Th documented evidence non-pharmacological Review of the 8/1/18 evidence documentat non-pharmacological An interview was con p.m. with RN (register manager. When aske follows when a reside #1 stated, "The staff's repositioning, some n ask them to rate their would be documented would document it on administration record Resident #108's July non-pharmacological stated, there was not | 2018 physician's orders ent non-pharmacological administering PRN (as or pain. Tylenol Tablet 325 2 tablet (sic) by mouth ded for pain." 2018 MAR (medication) documented, "Document interventions prior to edication for pain. Tylenol rams) Give 2 tablet (sic) by as needed for pain." On was documented that the nere was was no e that a intervention was attempted. nurse's notes did not cion regarding interventions. ducted on 8/8/18 at 12:55 red nurse) #1, the unit ed about the process staff ent complained of pain, RN should offer some on-medical treatment and pain." When asked if that d, RN #1 stated, "Yes. They the MAR (medication)." When asked to review and August MAR for the documentation, RN #1 | {F 8 | 342} | | | | |

Facility ID: VA0249

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 09/04/2 FORM APPRO OMB NO. 0938-0 | | |
|----------------------------|---|--|---|--|--|--|--|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE (A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 495109 | B. WING | | R 08/08/2018 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | • | STI | REET ADDRESS, CITY, STATE, ZIP CO | | | |
| THE LAUF | RELS OF UNIVERSITY P | ARK | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | | |
| (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 ACTIV CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE COMPLETE HE APPROPRIATE DATE | | |
| {F 842} {F 880} SS=D | complained of pain, L it's (the pain) between you. Like say it's (the may offer a warm cor if it would help first (p medication)." When a documented, LPN #3 to be." When asked to LPN #3 stated she dii non-pharmacological have documented the On 8/8/18 at 2:50 p.m member) #1, the adm director of nursing, A specialist and ASM # clinical operations we findings. Infection Prevention & CFR(s): 483.80(a)(1) §483.80 Infection Con The facility must esta infection prevention a designed to provide a comfortable environm development and tran diseases and infection §483.80(a) Infection p program. The facility must esta and control program a a minimum, the follow | aff follows when a resident PN #3 stated, "I ask them if n one to ten and they tell pain) is in their shoulder you mpress or massage it to see rior to giving pain asked if this would be a stated, "Yes. It's supposed o review the resident's MAR, d attempt interventions, but must not em. n. ASM (administrative staff ninistrator, ASM #2, the SM #3, the clinical transition 4, the regional director of ere made aware of the & Control (2)(4)(e)(f) ntrol blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at | {F 842} | | 8/31/18 | | |

Facility ID: VA0249

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| | MENT OF HEALTH AN | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 09/04/2018 MAPPROVED). 0938-0391 |
|--------------------------|---|--|---------------------|--|--|-------------------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | _ | | २ 08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | 420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 880} | staff, volunteers, visite providing services un- arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicab infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how isco resident; including bu (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possil circumstances. (v) The circumstances must prohibit employed disease or infected sk contact will transmit th (vi)The hand hygiene by staff involved in dir | seases for all residents, brs, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and bgram, which must include, lance designed to identify ble diseases or can spread to other in possible incidents of se or infections should be asmission-based precautions ent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable sin lesions from direct is or their food, if direct he disease; and procedures to be followed rect resident contact. | {F 880} | | | | |

Facility ID: VA0249

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| | S FOR MEDICARE & | ID HUMAN SERVICES MEDICAID SERVICES | | | | RM APPROVE | |
|--------------------------|--|---|---------------------|---|----------------------------------|----------------------------|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 495109 | B. WING | | R 08/08/2018 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CO | DDE | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC' | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| {F 880} | Continued From page | e 60 | {F 88 | 0} | | | |
| | | lle, store, process, and s to prevent the spread of | | | | | |
| | IPCP and update the This REQUIREMENT by: | view. Ict an annual review of its ir program, as necessary. ⁻ is not met as evidenced n, staff interview, facility | | Ftag 880 | | | |
| | document review, clir facility document revi the facility staff failed practices for two of 1 sample, Resident #17 residents in the media | hical record review, and ew, it was determined that to follow infection control 5 residents in the survey 14 and #101; One of nine cation administration t #15; and in one of three | | 1. 1. Resident #114: Resi longer resides in the facility during the survey process the tubing was replaced. No ne outcome occurred as a resu practice. | , however he oxygen gative | | |
| | | led to discard Resident that was found on the floor | | 2. 2. Resident #101: The replaced and bagged appro negative outcome occurred this practice. | priately. No | | |
| | 2. The facility staff failed to store the nasal cannula according to infection control practices for Resident #101. | | | 3. 3. Resident #115- No outcome occurred as a resu practice. The staff member | ult of this | | |
| | 3. The facility staff fai in a sanitary manner | led to administer medication for Resident #115. | | during the survey process 4. The staff member was ec | ducated | | |
| | | led to open mayonnaise manner in one of three in dining room. | | during the survey process a negative outcome occurred this practice. | ind no | | |
| | The findings include: | | | All residents currently in the the potential to be affected. | | | |

Event ID: TEQ112

Facility ID: VA0249

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| D PLAN OF | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | PLE CONSTRUCTION | · · · | |
|--------------------------|-------------------------|---|---------------------|---|-----------|---------------------------|
| | | IDENTIFICATION NUMBER: | A. BUILDIN | G | CO | MPLETED |
| | | 495109 | B. WING _ | | | R 8/08/2018 |
| IAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | 0/00/2010 |
| | | | | 2420 PEMBERTON RD | | |
| THE LAUR | ELS OF UNIVERSITY PA | ARK | | RICHMOND, VA 23233 | | |
| (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) COMPLETIO DATE |
| {F 880} | Continued From page | N 61 | (F 0) | | | |
| 1 0005 | | | {F 88 | 50} | | |
| | | admitted to the facility on es that included but were not | | The DON or designee will educ | ate | |
| | • | fracture of the left tibia, | | licensed nursing staff on the pr | | |
| | • | respiratory failure, high | | storage of respiratory equipme | • | |
| | blood pressure, and E | | | infection control practices with | | |
| | | d prostate). Resident #114's | | pass. Education will be provide | | |
| | most recent MDS (min | | | sanitary serving in the dining ro | om with | |
| | | day scheduled assessment | | licensed nursing staff. | | |
| | - | ment reference date) of | | The DON or designed will audi | Lourropt | |
| | 7/9/18. Resident #11 | e ability to make daily | | The DON or designee will audi residents on oxygen for proper | | |
| | | out of possible 15 on the | | tubing. Medication pass observ | • | |
| | ÷ | for mental Status) exam. | | be completed on all licensed n | | |
| | • | oded in Section 0 (Special | | Dining room observations for s | • | |
| | treatments, procedure | · · | | sanitary manner will be conduc | | |
| | receiving respiratory s | services. | | for 5 days. | | |
| | Review of Resident # | 114's August 2018 POS | | The DON or designee will cond | luct | |
| | | mary) revealed the following | | medication pass observations | | |
| | order: "Oxygen 2 L (lit | ters) via nasal cannula | | week for 4 weeks. Dining room | | |
| | | t. Keep 02 sats (saturation) | | observations will be conducted | | |
| | above 90 % (percent) |)." | | week for 4 weeks. Room round | | |
| | | | | oxygen storage will be conduct | | |
| | | m., an observation was | | a week for 4 weeks. Additiona | | |
| | | 14's oxygen. He was not in tubing that was hooked to | | and/or counseling will be provid indicated. Concerns will be rep | | |
| | | tor was found on the floor. | | the DON/Designee to the quali | | |
| | | as dated "8/14/18" as the | | assurance committee. | Ly . | |
| | date to be changed no | | | | | |
| | 0 | | | Continued compliance will be r | nonitored | |
| | On 8/8/18 at 10:49 a. | m., CNA (certified nursing | | though the facility⊡s quality as | | |
| | - | served in Resident #114's | | program. Additional education | | |
| | | oserved making Resident | | monitoring will be initiated for a | ny | |
| | | vas then observed picking | | identified concerns. | | |
| | | off the floor. CNA #1 then | | Completion Date: | | |
| | | tubing and placed it in the anging from the oxygen | | Completion Date: August 31,2018 | | |
| | concentrator. | анушу пош ше охуден | | | | |

If continuation sheet Page 62 of 70

| DEPARTMENT OF HEALTH ANI CENTERS FOR MEDICARE & N | | | | F | NTED: 09/04/2018 FORM APPROVED B NO. 0938-0391 |
|--|---|------------------------------|--|---|--|
| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | E CONSTRUCTION | (X3) | DATE SURVEY COMPLETED |
| | 495109 | B. WING | | | R 08/08/2018 |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE | , ZIP CODE | |
| THE LAURELS OF UNIVERSITY PA | RK | | 420 PEMBERTON RD RICHMOND, VA 23233 | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIV CROSS-REFERENCE | AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY) | (X5) COMPLETION DATE |
| CNA #1 stated that oxy stored in a plastic bag, should be stored in a p to prevent contaminati what she would do if s tubing on the floor, CN throw it away and get a When asked if it was e tubing that was found plastic bag, CNA #1 st not be placed back in th asked if she placed Re tubing back in the plass on the floor, CNA #1 s it in the plastic bag. W of the above observati CNA #1 stated. "So I h #1 stated she could no #114's oxygen tubing h it was found on the floor On 8/8/18 at 1:13 p.m. conducted with RN (re manager. When asked be stored when not in oxygen tubing should I to prevent contaminati should be done if oxyg floor, RN #1 stated that changed. RN #1 stated on the floor should new plastic storage bag. On 8/8/18 at 2:51 p.m. | n., an interview was 1. When asked how be stored when not in use, ygen tubing should be . When asked why tubing blastic bag, CNA #1 stated ion of germs. When asked the were to find oxygen VA #1 stated that she would a new one from the nurse. ever okay to place oxygen on the floor, back in the tated that the tubing should the plastic bag. When esident #114's oxygen stic bag after it was found tated that she did not place Vhen CNA #1 was informed ions made at 10:49 a.m., have to throw it away?" CNA of recollect placing Resident back in the plastic bag after or. ., an interview was registered nurse) #1, a unit d how oxygen tubing should use, RN #1 stated that be stored in a plastic bag, ion. When asked what gen tubing is found on the at the tubing should be d that oxygen tubing found ver be placed back in the ., ASM (administrative staff nistrator, ASM #2, the DON | {F 880} | | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 | |
|--------------------------|---|---|--------------------|------|--|------------------------------------|----------------------------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED R | | |
| | | 495109 | B. WING | | | 08/08/2018 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE LAU | E LAURELS OF UNIVERSITY PARK | | | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| {F 880} | Transition Specialist, Director of Operations above concerns. No further information A policy could not be above concern. 2. The facility staff fail cannula according to for Resident #101. Resident #101 was au 7/8/18 with diagnoses limited to: fractured pu dementia and arthritis The most recent MDS day assessment, with reference date) of 7/2 having scored a three (brief interview for me resident was severely resident was coded a staff for all activities o eating which the resident initiated on 7/19/18 di oxygen order. An observation was no 8/7/18 at 12:55 p.m. of The resident was not nasal cannula (soft pl nose to deliver oxyge | and ASM #4, the Regional s was made aware of the a was presented prior to exit. provided regarding the led to store the nasal infection control practices dmitted to the facility on s that included but were not elvis, high blood pressure, s. 6 (minimum data set), a 14 a n ARD (assessment 2/16 coded the resident as e out of 15 on the BIMS ental status) indicating the r impaired cognitively. The s requiring assistance from f daily living except for lent could perform after the resident was coded as | {F 8 | 380} | | | | |

Facility ID: VA0249

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 09/04/2018 1 APPROVED 0. 0938-0391 |
|--------------------------|---|--|--------------------|-----|--|---|-------------------|---|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | | | २ 08/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | | • | S | TREET ADDRESS, CITY, STATE | E, ZIP CODE | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | | 420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | (EACH CORRECT) CROSS-REFERENCE | AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY) | | (X5) COMPLETION DATE |
| {F 880} | Continued From page | 3 64 | {F 8 | 80} | | | | |
| | of Resident #101. The wheelchair. The nasa the oxygen concentra tank on the back of th nasal cannula was fol cannula was uncovered An observation was m of Resident #101. The wheelchair. The nasa the bed uncovered. The to the oxygen tank on uncovered. An observation was m of Resident #101 was The resident was weat oxygen concentrator. to the oxygen tank on uncovered. | nade on 8/8/18 at 8:47 a.m. e resident was up in the il cannula was lying across the nasal cannula attached the wheelchair, remained nade on 8/8/18 at 10:10 a.m. s sitting in the wheelchair. aring the oxygen via the The nasal cannula attached the wheelchair, remained | | | | | | |
| | of Resident #101 with nurse. The resident w nasal cannula was lyi | nade on 8/8/18 at 12:48 p.m. h LPN #3, the resident's vas not in the room. The ng on the floor. LPN #3 left ing the nasal cannula up off | | | | | | |
| | p.m. with RN (register manager. When aske was to be stored when "In a bag." When aske doesn't get dirty. Keep what staff would do if | ducted on 8/8/18 at 12:55 red nurse) #1, a unit ed how the nasal cannula n not in use, LPN #3 stated, ed why, RN #1 stated, "So it ps it cleaner." When asked the nasal cannula was on d, "You need to change it." | | | | | | |

Facility ID: VA0249

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 | |
|--------------------------|--|--|--------------------|-----|---|-------------------|----------------------------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | PLE CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED | |
| | | 495109 | B. WING | | | R 08/08/2018 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 | | |
| THE LAU | THE LAURELS OF UNIVERSITY PARK | | | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| {F 880} | p.m. with LPN #3. Whe cannula was to be store #3 stated, "We have the baggie." When asked the oxygen tank was a "It's supposed to be in asked where the resident the observation at 12: think it was on the best observed on the floor of it." On 8/8/18 at 2:50 p.m member) #1, the adm director of nursing, AS specialist and ASM #4 clinical operations we findings. Review of the facility's concentrators did not of oxygen tubing. No further information In "Fundamentals of M Patricia A. Potter and Inc; Page 648. "Box of Health Care-Assoc Respiratory Tract C therapy equipment." The facility staff failin a sanitary manner to Resident #115 was as 3/1/17 and readmittee. | ducted on 8/8/18 at 1:35 hen asked how the nasal pred when not in use, LPN to put the tubing in a little how the nasal cannula on to be stored, LPN #3 stated, in a little baggie too." When dent's oxygen was during '48 p.m., LPN #3 stated, "I d." When informed it was , LPN #3 stated, "I'll get rid h. ASM (administrative staff inistrator, ASM #2, the SM #3, the clinical transition 4, the regional director of re made aware of the s policy on oxygen address the proper storage h was obtained prior to exit. Nursing" 7th edition, 2009: Anne Griffin Perry: Mosby, 34-2 Sites for and Causes iated Infections under contaminated respiratory | {F ε | 380 | D} | | | |

Facility ID: VA0249

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 | |
|--------------------------|--|---|--------------------|---|--|-------------------------------|----------------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | `, | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 495109 | B. WING | | | R 08/08/2018 | | |
| | ROVIDER OR SUPPLIER | ARK | | : | STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| {F 880} | Continued From page dementia, kidney can pressure. The most recent minina assessment, with an a of 5/17/18 coded the out of 15 on the brief indicating the residen cognitively. The resid assistance from staff living. A medication adminis conducted on 8/8/18 a (licensed practical nu card of colchicine (1) LPN #5 popped the p fell onto the top of the then scooped the pill LPN #5 then administ Resident #115. Review of the August documented, "Colchic (milligrams) Give 1 ta day for gout (2)." | e 66 cer and high blood mum data set, a quarterly assessment reference date resident has having an eight interview for mental status t was severely impaired ent was coded as requiring for all activities of daily tration observation was at 8:45 a.m. with LPN rse) #5. LPN #5 took a pill from the medication cart. ill out of the card and the pill e medication cart. LPN #5 up into a medication cup. tered the medication to 2018 physician's orders cine Tablet 0.6 MG blet by mouth one time a | {F 8 | | DEFICIENCY) | | | |
| | p.m. with LPN #5. Wh medication cart was of stated she normally w beginning of the shift. if a pill fell onto the to | when asked if the top of the considered clean, LPN #5 viped her cart off at the When asked what staff did p of the medication cart, it. I know I put it back in the | | | | | | |

Facility ID: VA0249

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 | |
|--------------------------|--|---|-------------------|------|---|-------------------|----------------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED | |
| | | 495109 | B. WING | | | R 08/08/2018 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ЗE | (X5) COMPLETION DATE | |
| {F 880} | cup." When asked wh medication, LPN #5 s An interview was com p.m. with LPN #7, a u what staff should do i medication cart, LPN discard the pill." Whe stated, "It's dirty." On 8/8/18 at 2:50 p.m member) #1, the adm director of nursing, AS specialist and ASM # clinical operations we findings. A request fo medication administra ASM #1 at that time. On 8/8/18 at 4:40 p.m not have a policy. No further information 1. Colchicine is used gout (also called gout was obtained from: https://search.nih.gov %E2%9C%93&affiliat 2. Gout - Gout is a co arthritis. It causes sw Gout happens when u body. This information https://search.nih.gov %E2%9C%93&affiliat 4. The facility staff fai | hy staff discarded the tated, "Contamination." ducted on 8/8/18 at 2:35 init manager. When asked f they drop a pill on the #7 stated, "They need to in asked why, LPN #7 h. ASM (administrative staff inistrator, ASM #2, the SM #3, the clinical transition 4, the regional director of re made aware of the r the facility's policy on ation was requested from h., ASM #3 stated she did h was provided prior to exit. to prevent or treat attacks of y arthritis). This information //search?utf8= te=nih&query=cochicine mmon, painful form of ollen, red, hot and stiff joints. uric acid builds up in your h was obtained from: //search?utf8= | {F 8 | 380} | | | | |

Facility ID: VA0249

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 09/04/2018 // APPROVED). 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|----------|-------------------|--|
| STATEMENT O | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 495109 | B. WING | | | | | २ 08/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE LAUF | RELS OF UNIVERSITY PA | ARK | | | 420 PEMBERTON RD NCHMOND, VA 23233 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | IOULD BE | | (X5) COMPLETION DATE |
| {F 880} | p.m. in the main dinin observed taking a pair uniform pocket and com mayonnaise packet and on the edge of the rest replaced the scissors. Another observation where scissors out of the off another mayonnais replacing the scissors not clean the scissors mayonnaise packets. An interview was comp.m. with LPN #4. Whe pockets were consider "No." When asked ab before and after using stated, "Wipe them w When asked what she the dining room the erstated, "I used them to packets." An interview was comp.m. with RN (register manager. When asket follows when using th "She should wipe the alcohol." The above of RN #1. RN #1 stated, down." When asked w | in dining room. was made on 8/7/18 at 4:40 g room. LPN #4 was r of scissors out of her utting off the top of a nd then placing the packet sident's plate. LPN #4 back into her pocket. was made of LPN #4 taking r pocket and cutting the top se packet and then a into her pocket. LPN #4 did g prior to or after cutting the ducted on 8/8/18 at 12:45 hen asked if her uniform ered clean, LPN #4 stated, out the process staff follows g their scissors, LPN #4 ith alcohol before and after." e used her scissors for in vening before, LPN #4 o open up the mayo duction on 8/8/18 at 12:55 red nurse) #1, the unit d about the process staff eir scissors, RN #1 stated, m down with a bleach pad or observation was described to "She didn't wipe them vhy the scissors should be d, "So don't pass on germs." | {F 8 | 80} | DEFICIENCY) | | | |
| | | n. ASM (administrative staff inistrator, ASM #2, the | | | | | | |

Facility ID: VA0249

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | FOR | D: 09/04/2018 MAPPROVED O. 0938-0391 |
|--------------------------|---|--|---------------------|--|-----------------|--|
| STATEMENT | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DAT | E SURVEY IPLETED |
| | | 495109 | B. WING | | 08 | R 8/08/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | I | | STREET ADDRESS, CITY, STATE, ZIP | | |
| THE LAU | RELS OF UNIVERSITY PA | ARK | | 2420 PEMBERTON RD RICHMOND, VA 23233 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE | (X5) COMPLETION DATE |
| {F 880} | director of nursing, As specialist and ASM # clinical operations we findings. A request fo cleaning medical equ ASM #1 at that time. | e 69 SM #3, the clinical transition 4, the regional director of the made aware of the r the facility's policy on ipment was requested from h was obtained prior to exit. | {F 880 | } | | |

Facility ID: VA0249

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