DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING ______ B. WING ______	C 06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/28/16 through 6/30/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 124 bed certified facility was 99 at the time of the survey. The survey sample consisted of 19 current resident reviews (Residents #1 through #17 and Residents #23-#24) and five closed record reviews (Residents #18 through #22).	F 000	The Laurels of Bon Air wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is July 29, 2015. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	F Tag 164: 1) Facility staff strives to maintain visual privacy when administering medication for one resident. Resident #1 did not have full visual privacy during medication administration. Education was immediately provided to LPN #2.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ryan Koenig (signature) TITLE: Administrator (X6) DATE: 7/21/16

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

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide personal privacy and confidentiality of records for three of five residents in the medication administration observation, (Resident # 1, 4, and 23); and for one of 24 residents in the survey sample; (Resident #24). 1) Facility staff failed to maintain full visual privacy when administering Resident #1's medications. 2) During medication administration observation, facility staff failed to properly dispose of patient sensitive information printed on the medication packets by throwing the packets into the regular trash for Resident #1, #4, #23 and #24. The findings include: 1. Resident #1 was admitted to the facility on 1/2/15 with diagnoses that included but were not limited to atrial fibrillation, high blood pressure, arthritis, osteoporosis, Non-Alzheimer's Dementia, anxiety disorder and depression. Resident #1's most recent MDS (minimum data set) was a significant change MDS with an ARD (assessment reference date) of 5/10/16.	F 164	All residents have the potential to be affected. The DON or designee will validate LPN #2's competency of medication pass for compliance 3 times. The DON or designee will educate all licensed nurses regarding maintaining full visual privacy during medication administration. On-going compliance will be monitored through review of quarterly medication pass observations. Additional education and monitoring will be initiated for any identified concerns. Variances will be reviewed in the monthly quality assurance meeting with additional monitoring and education provided as needed.	

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F 164	Continued From page 2 Resident #1 was coded as being severely cognitively impaired in the ability to make daily life decisions scoring 7 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring extensive assistance from staff with transfers, dressing, eating, toileting and personal hygiene, and total dependence on staff with bathing. On 6/29/16 at 7:55 a.m., a medication administration observation was conducted with LPN (Licensed practical nurse) # 2. At 7:55 a.m., LPN # 2 prepared and administered the following medications for Resident #1: Tramadol (1) 3 half tablets to =75 mg (milligrams) Restasis (2) 0.05 percent - 1 gtt (drop) to both eyes Flecaintide acetate (3) 50 mg- 1 tablet Lasix (4) 20 mg - 1 tablet Losartan Potassium (5) 25 mg -1 tablet prednisone (6) 2.5 mg- 1 tablet Zoloft HCL (hydrochloride) (7) 100 mg - 1 tablet Klon Chlor (8) 20 MEQ (Milliequivlants)- 1 tablet At 8:09 p.m., LPN #2 crushed all medications together and added applesauce to the medication cup. She walked over to Resident #1 who was sitting in the hallway behind the medication cart next to two other residents. LPN #2 stated, "Hi Mrs. (name of resident). I have your medication." LPN #2 administered the pills to Resident #1 and then administered the eye drops to Resident #1 in the hallway. LPN #2 did not ask Resident #1 for permission to give the medications in public. On 6/29/16 at 8:36 a.m., an interview was conducted with LPN #2. When asked how to maintain resident privacy during medication pass	F 164	2) Facility staff strives to properly dispose of patient sensitive information printed on the medication packet when discarding the packets in the trash. Residents #1, #4, #23 & #24 had patient sensitive information on medication packets thrown away without proper disposal. Education was given to nurses on proper disposal of the medication packets. All residents have the potential to be affected. The DON or designee will educate LPN's #2 & #7 regarding proper disposal of pill packets by ablation of names. All licensed nurses will be re-educated regarding disposal of medication packets providing confidentiality of patient information by ablation of name prior to disposal.	

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F 164	Continued From page 3 she stated that nurses should take the resident to their rooms. When asked if she asked permission to give the medications in the hallway to Resident #1 she stated, "I didn't." On 6/30/16 at 10:00 a.m., an interview was conducted with LPN #8. When asked how to maintain privacy when administering medications to residents, she stated that residents must be in their rooms with the curtain pulled. She stated, "They are not supposed to be given in the hallway." On 6/30/16 at 10:15 a.m., an interview was conducted with LPN #1. When asked how to maintain privacy and dignity when administering medications she stated that nurses should take the resident to their room or ask them permission to give it in a public place prior to giving the medication. She stated that administering medications in public without permission is a dignity issue. She stated, "Some patients may not want to take medications in the hallway." On 6/29/16 at 5:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the corporate nurse was made aware of the above findings. Facility policy titled, "Medication Administration" did not address the above concerns. No further information was presented prior to exit. According to Fundamentals of Nursing, Potter and Perry 6th edition, page 414; "Nursing standards for what constitutes confidentiality information are based on professional ethics and	F 164	Random audits for compliance after medication administration will be conducted for compliance 3 times per month for 3 months. Variances will be reviewed in the monthly quality assurance meeting with additional monitoring and education provided as needed. Completion date: July 29, 2016	

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the common law. The ideals of privacy and sensitivity to the needs and rights of clients who may not choose to have nurses intrude on their lives, but who depend on nurses for their care, guide the nurse's judgment."

(1) Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.

(2) Restasis- Used to increase tear production in those with dry eye disease. This information was obtained from the National Institutes of Health. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a604009.html.

(3) Flecaintide acetate- used to prevent certain types of life threatening irregular heartbeat. This information was obtained from The National Institutes of Health. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a608040.html.

(4) Lasix 20 mg- used to decrease edema (excess fluid) in patients with heart failure, liver impairment or kidney disease. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 587.

(5) Losartan Potassium- Used to decrease blood pressure. This information was obtained from The National Institutes of Health. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a695008.html.

(6) Prednisone 2.5 mg-corticosteroid used to suppress inflammation and the normal immune

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response. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 351.

(7) Zoloft HCL 100 mg-antidepressant that is also used to treat generalized anxiety disorder. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 1103.

(8) Klon Chlor 20 MEQ-used as a supplement for the prevention of potassium deficiency. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 997.

2. During the medication administration observation, facility staff failed to properly dispose of patient sensitive information printed on the medication packets by throwing the packets into the regular trash for Resident #1, #4, #18 and #24.

Resident #1 was admitted to the facility on 1/2/15 with diagnoses that included but were not limited to atrial fibrillation, high blood pressure, arthritis, osteoporosis, Non-Alzheimer's Dementia, anxiety disorder and depression. Resident #1's most recent MDS (minimum data set) was a significant change MDS with an ARD (assessment reference date) of 5/10/16. Resident #1 was coded as being severely cognitively impaired in the ability to make daily life decisions scoring 7 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Resident #4 was admitted to the facility on 8/15/2014 with diagnoses that included but were

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F 164	Continued From page 6 not limited to high blood pressure, high cholesterol, Non-Alzheimer's Dementia, and psychotic disorder. Resident #4's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/28/16. Resident #4 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 5 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #23 was admitted to the facility on 4/27/16 with diagnoses that included but were not limited to high blood pressure, high cholesterol, stroke, and Non-Alzheimer's dementia. Residents #23's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/16/16. Resident #23 was coded as being severely cognitively impaired in the ability to make daily life decisions scoring 4 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #24 was admitted to the facility on 6/16/16 with diagnoses that included but were not limited to atrial fibrillation, high blood pressure, Non-Alzheimer's Dementia, difficulty in walking, and muscle weakness. Resident #24's most recent MDS (minimum data set) was an admission assessment with an ARD of 6/23/16. Resident #24's was coded as being moderately impaired in cognitive status scoring 8 out of 15 on the BIMS. On 6/29/16 at 7:55 a.m., a medication administration observation was conducted with LPN (Licensed practical nurse) # 2. At 7:55 a.m., LPN # 2 prepared and administered the following medications for Resident #1:	F 164		

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F 164	Continued From page 7 Tramadol 3 half tablets to =75 mg (milligrams) Restasis 0.05 percent - 1 gtt (drop) to both eyes Flecaintide acetate 50 mg- 1 tablet Lasix 20 mg - 1 tablet Losartan Potassium 25 mg -1 tablet prednisone 2.5 mg- 1 tablet Zoloft HCL (hydrochloride) 100 mg - 1 tablet Klon Chlor 20 MEQ (Milliequivlants)- 1 tablet At 8:00 a.m., after LPN #2 popped each pill into the cup, she threw away both pill packages into the regular trash that had the resident's name on the package. The name was not ablated off the pill package. On 6/29/16 at 8:15 p.m., LPN #2 was observed preparing the following medications for Resident # 23: Aspirin (9) 81 mg- 1 tablet Norvasc (10) 10 mg - 1 tablet Plavix (11)75 mg - 1 tablet At 8:20 a.m., after LPN #2 popped each pill into the cup, she threw away the pill package into the regular trash that had the resident's name on the package. The name was not ablated off the pill package. On 6/29/16 at 8:21 a.m., LPN #2 was observed preparing the following medications for Resident #4: Norvasc 10 mg- 1 tablet Flecaintide acetate 50 mg- 1 tablet Lipitor (12) 10 mg - 1 tablet Colace (13) 100 mg - 1 tablet Ocuvite Lutein (14) - 1 tablet Namenda (15)28 mg - 1 tablet	F 164		

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Spironlactalone (16) 25 mg- 1 tablet

On 6/29/16 at 8:28 a.m., after LPN #2 administered Resident #4's medications she threw away the pill package into the regular trash with Resident #4's name still attached to the package. Resident #4's name was not ablated off the package.

On 6/29/16 at 8:36 a.m. an interview was conducted with LPN #2. When asked where the medication cart trash goes after medication pass is completed, she stated that trash went into the soiled utility room at the end of each shift. When asked where patient sensitive items such as documents with residents' name on them go to be discarded she stated that the facility had a shredder box. When asked if it was ok to throw away pill packages with the residents' names still attached to the package, LPN #2stated, "Yes, we usually discard them in the trash but we try to rip the name of the top and place it all in the trash."

On 6/29/16 at 9:00 a.m., observation of a medication cart on the downstairs unit was conducted. A pill package was noted in the regular trash with Resident #24's name visibly on the package. At 9:10 a.m., LPN #7 was observed coming out of another resident's room. At 9:10 a.m. an interview was conducted with LPN #7. When asked if Resident #24's name was still attached to the pill package in the trash, LPN #7 stated that it was. When asked where the medication cart trash goes to after medication pass is completed, LPN #7 stated, "It goes straight outside to the main trash." When asked where documents or anything with residents' names on it should go, LPN #7 stated, "We will try to put those things in the shredder." When

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asked if it was ok to throw away pill packages with residents' name still attached, LPN #7 stated, "That's where we have been putting them."

On 6/29/16 at 5:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse was made aware of the above findings. ASM #3 stated that the names on the packages should have been completely ablated off the top of the packages. She stated that the facility had just put the new pharmacy system into place on 6/29/16 at 12:00 a.m.

On 6/30/16 at 8:55 a.m. further interview was conducted with ASM #3. ASM #3 stated that the facility was so focused on making sure the medication carts were ready to try out the new pharmacy system that the facility did not think to educate the nurses to make sure they ablated the names off the packages properly. She stated that the nurses were educated on how to ablate the name by using a permanent marker to prevent resident sensitive information from getting into the regular trash. She stated that this new system was different for the facility and they had only been using the system for less than 48 hours.

No policy could be provided regarding the above concern. No further information was provided prior to exit.

(9) Aspirin- "Used to decrease mild to moderate pain associated with inflammatory disorders." This information was obtained from Davis's Drug Guide, 11th edition, p. 1087.
(10) Norvasc-Used to decrease blood pressure.

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F 164	Continued From page 10 This information was obtained from Davis's Drug Guide, 11th edition, p. 151. (11) Plavix-antiplatelet used to thin the blood. Used to prevent stroke. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 325. (12) Lipitor- used to decrease cholesterol. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 629. (13) Colace-Used to soften the passage of stool. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 442. (14) Ocuvite Lutein-Used to prevent age related macular degeneration. This information was obtained from the National Institutes of Health. https://nei.nih.gov/amd/summary. (15) Namenda-used to lessen symptoms associated with Alzheimer's dementia. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 783. (16) Spironlactalone- used as a weak diuretic (pulls fluid off) and used to decrease blood pressure. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 432.	F 164		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:	F 272		

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F 272	Continued From page 11 Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review it was determined that facility staff failed to document date and location for triggered areas on the CAA (Care Area Assessment summary) in Section V of the MDS (minimum data set) assessment for one of 24 residents in the survey sample; Resident #2.	F 272	F Tag 272: The facility strives to document the date and location for triggered areas on the CAA summary in the MDS. The location and date of information from the clinical record was not recorded to complete the assessment of the triggered areas of "Nutritional Status" on the CAA in Section V of Resident #2's admission MDS assessment. The CAA section was addressed by updating the location and date information. All residents have the potential to be affected. Prior to signing and locking comprehensive assessments the MDS Coordinator will review each CAA to ensure completion. Employees responsible for completing MDS sections will be educated by the MDS Coordinator on completing all parts of the MDS assessment.	

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F 272	Continued From page 12 The facility staff failed to document the location and date of information from the clinical record that was utilized to complete the assessment of the triggered area of "Nutritional Status" on the CAA in Section V, of Resident #2's admission MDS assessment with an ARD (assessment reference date) of 2/08/16. The findings include: Resident #2 was admitted to the facility on 2/8/16 and readmitted on 6/28/16 with diagnoses that included but not limited to spinal stenosis(1) , insomnia, depression, chronic kidney disease, GI (gastrointestinal) bleed and muscle weakness. Resident #2's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/12/16. The resident was coded as being cognitively intact in the ability to make daily life decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #2 was coded as requiring extensive assistance from staff with transfers and personal hygiene; dependent on staff with bathing, and independent with meals. A review of the clinical record revealed the most recent comprehensive MDS was the admission MDS with an ARD of 2/08/16. This review revealed in Section V (Care Area Assessment (CAA) Summary), a column, titled "Location and Date of CAA documentation." The data contained in this column for the triggered area: "nutritional status" did not contain a date and location of information. Review of the CAA worksheets failed to reveal the date and location of information for triggered area, "Nutritional Status." On 6/30/16 at 11:27 a.m., an interview was conducted with RN (Registered Nurse) #3, the director of MDS. She stated that the nutritional CAA for Resident #2 was overlooked. She stated	F 272	Assessments will be randomly audited for accuracy and completion weekly for 4 weeks. Variances will be reviewed in the monthly quality assurance meeting with additional monitoring and education provided as needed. Completion date: July 29, 2016	

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THE LAURELS OF BON AIR	**9101 BON AIR CROSSINGS DRIVE** **BON AIR, VA 23235**

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F 272	Continued From page 13 that date and location is the date and the location in the clinical record where information was found to support the triggered CAA. She stated that the facility uses the RAI (Resident Assessment Instrument) manual when completing the MDS. On 6/30/16 at approximately 1:00 p.m., ASM (Administrative Staff Member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse where made aware of the above findings. No further information was presented prior to exit. Section V of the MDS documents at the top of the page the following instructions: 1. Check column A if the Care Area is triggered. 2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Addressed in the Care Plan column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan. 3. Indicate in the Location and Date of CAA information column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks and any referrals for this resident for this care area. Review of CMS's (Center of Medicare/Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 User's Manual documented, "CHAPTER 4: CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLANNING. 4.5 Other Considerations Regarding Use of the	F 272		

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F 272	Continued From page 14 CAAs. Use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's record. Also indicate in the column "Care Planning Decision" whether the triggered care area is addressed in the care plan." (1) "Spinal stenosis causes narrowing in your spine. The narrowing puts pressure on your nerves and spinal cord and can cause pain." This information was obtained from the National Institutes of Health. https://www.nlm.nih.gov/medlineplus/spinalstenosis.html.	F 272		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to meet professional standards of practice for one of 24 residents in the survey sample, Resident # 20. The facility staff failed to correctly transcribe a physician ordered medication for administration to Resident #20. The findings include:	F 281		

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F 281	Continued From page 15 Resident #20 was admitted to the facility on 8/25/214 with a readmission on 2/25/15 with diagnoses that included, but were not limited to; dementia, COPD (chronic obstructive pulmonary disease - causes difficulty with breathing), high blood pressure and atrial fibrillation (irregular heart beat). Resident #20's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 2/26/16. Resident #20 was coded as a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was moderately cognitively impaired. A review of Resident #20's clinical record revealed, in part, the following telephone orders; 12/30/15, signed and dated by the physician on 1/5/16; "12/30/15 Morphine (used to treat moderate to severe pain (1)) 20 mg (milligrams) / ml (milliliter) 0.25 ml Q3H prn (every three hours as needed) sob (shortness of breath)." 3/15/16, signed and dated by the physician on 3/15/16;"D/C (discontinue) morphine. Morphine 20 mg / ml give 0.25 ml (5 mg) po (by mouth) / sl (sublingual - beneath the tongue) q1 (every one) hour prn (as needed) for pain / sob." Further review of Resident #20's clinical record revealed, in part, the following prescription renewal forms sent to the pharmacy to be filled; "(Name of Resident #20) Morphine 20 mg / ml 0.25 ml (5 mg) po q3 hrs (every three hours)." signed by the nurse practitioner and dated 3/14/16. "(Name of Resident #20) Morphine 20 mg / ml.	F 281	F Tag 281: The facility strives to correctly transcribe physician ordered medications. Resident #20 did not have correctly transcribed physician ordered medications for administration. There were no negative outcomes. Resident #20 was a hospice patient and expired. All residents have the potential to be affected. The DON or designee will educate all licensed nurses on correct electronic order entry and following physician orders. The administrative nurses will check orders during clinical operations meeting for correct entry 5 times per week for 4 weeks. Variances be reviewed in the monthly quality assurance meeting with additional	

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F 281	Continued From page 16 0.25 ml (5 mg) po / sl q1 hr (every one hour) prn (as needed) pain / sob." signed by the physician and dated 3/15/16. A review of Resident #20's physician order sheet of active orders dated 3/1/16 - 3/31/16 revealed, in part, the following documentation; "Start 12/30/15 End 2/28/17. Active recertified as of 2/29/16. Morphine Sulf (sulfate) 100 MG/5 ML soln (solution) 0.25 ML oral every 3 hours pain. Telephone order from (name of primary physician) taken by (name of nurse) noted on 12/30/15 7:11 p.m. by (name of nurse)." A review of Resident #20's MARs (medication administration records) dated January 2016, February 2016 and March 2016 revealed, in part, that Resident #20 was documented as receiving Morphine sulfate under the following order: "Morphine sulfate 100 mg /5 ml soln. 0.25 ml every 3 hours; oral for pain." Resident #20 received the medication one time each day at midnight between 1/1/2016 and 3/18/2018. Further review of Resident #20's January, February and March 2016, MARs revealed only one documented time (midnight) and one box below this time for administering and signing for the administration of the Morphine Sulfate ordered to be administered every three hours to Resident #20. There were no other boxes and times documented on the MARs for administering the Morphine Sulfate every three hours as ordered by the physician. On 6/30/16 at 9:25 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked to review the Morphine Sulfate order	F 281	monitoring and education provided as needed. Completion date: July 29, 2016	

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F 281	Continued From page 17 for Resident #20 and to explain what Resident #20 should have been administered from 1/1/16 to 3/18/16. ASM #2 reviewed the orders and stated that Resident #20 was to receive Morphine Sulfate every three hours. ASM #2 was asked whether or not Resident #20 was administered Morphine Sulfate every three hours, ASM #2 stated that he was not. ASM #2 further stated, "They (the nursing staff) put the order in wrong, it (the computer system) did not give them enough times to document. It was entered incorrectly so it would not have flagged to be given." On 6/30/16 at approximately 12:30 p.m. a meeting was held with ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate nurse specialist. At this time the administrative staff present was made aware of the concerns. No further information was provided prior to the end of the survey. (1) This information was obtained from the following website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682133.html	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical	F 282		

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F 282	Continued From page 18 record review, and facility document review, it was determined that the facility staff failed to follow the plan of care for one of 24 residents in the survey sample; Resident #12. The facility staff failed to ensure a clip alarm was on at all times, per Resident #12's plan of care. The findings include: Resident #12 was admitted to the facility on 6/8/16 with the diagnoses of but not limited to high blood pressure, coronary artery disease, atrial fibrillation, shortness of breath, seizures, bladder spasms, neurogenic bladder, and a suprapubic catheter. The most recent MDS (Minimum Data Set) was an admission MDS with an ARD (Assessment Reference Date) of 6/15/16. The resident was coded as severely cognitively impaired in ability to make daily life decisions, scoring a 7 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for transfers and hygiene; limited assistance for dressing and ambulation; and supervision for eating. The resident was coded as having no range of motion limitations of upper and lower extremities. A review of the clinical record revealed a physician's order dated 6/8/16 for "Safety Alarm: Sensor Alarm to Bed/Chair. Check placement and function every shift." On 6/28/16 at 2:52 p.m., an observation was made of Resident #12. He was in his wheelchair in his room next to his bed (window bed) and next	F 282	Tag 282: The facility strives to follow the plan of care. Resident #12's care plan was not followed to ensure a clip alarm was on at all times. Resident #12's care plan has been revised. All residents have the potential to be affected. A pressure alarm was placed under resident #12's wheel-chair cushion on 6/30/16 to ensure compliance with the safety device. C.N.A. #2 received additional training regarding correct placement & checks of alarm placement & functioning. The DON or designee will educate all licensed staff on following the plan of care for safety devices to include proper function, the required documentation for any noncompliance of the	

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F 282	Continued From page 19 to him was a regular chair. He was turned around in his wheelchair, removing the clip alarm box hanging on the left handle of the wheelchair. Next he was fidgeting with the alarm and then laid it down in the regular chair next to him. He was then observed to get up out of the wheelchair, pivot, and sit on the bed. The alarm did not go off because there was too much slack in the cord from the clip attached to him to where the alarm was laying in the regular chair. By Resident #12 moving the alarm box, it ensured the alarm was closer to the bed and would not pull at the clip attached to him and activate the alarm. Resident #12 was then observed sitting on the bed and making phone calls. After a few minutes, he picked the alarm box up off the regular chair, and put it in his jacket pocket, further making the alarm less likely to be activated. At 3:00 p.m., CNA #2 (Certified Nursing Assistant) entered the resident's room, went all the way into the room near Resident #12, looked at Resident #12 and looked at his roommate, and left the room. She did not notice the alarm was not placed in any manner that would activate it if the resident had a fall, and did not correct the situation to ensure the alarm was being worn in a manner that would make it functional. On 6/30/16 at 10:30 a.m., Resident #12 was observed up in his wheelchair in his room near the door to the room. His clip alarm was not on. An observation of the resident's bed area failed to reveal where the clip alarm was at this time. Therapy staff was in the room with the roommate. On 6/30/16 at 3:39 p.m., an observation was made of Resident #12 sitting in his wheelchair in the therapy room. He was at the table, not doing any activities. His clip alarm was not on.	F 282	resident use of safety devices & the updating of the care plan as needed. Compliance will be monitored through random checks of resident safety devices for 5 times per week for 4 weeks. Variances will be reviewed in the monthly quality assurance meeting with additional monitoring and education provided as needed. Completion date: July 29, 2016	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	Continued From page 20	F 282		

On 6/30/16 at 3:55 p.m., an observation was made of Resident #12 in his wheelchair in the hallway. The clip alarm was on at this time. At this time, an interview was conducted with OSM #5 (Other Staff Member), the physical therapist, that was in the hallway near Resident #12. OSM #5 was asked about the clip alarm and informed of the observation of the alarm not in place on the resident 20 minutes earlier, in the therapy room. OSM #5 was asked if she knew anything about when the clip alarm was put on Resident #12. OSM #5 stated she did know because she was present when the nurse came and put it on him (LPN #7 - Licensed Practical Nurse).

On 6/30/16 at 3:58 p.m., an interview was conducted with LPN #7. She stated that the resident is supposed to have it on at all times but that he is non-compliant with it.

A review of the care plan revealed one for "Falls: At risk for fall related injury related to: Unsteady gait, impaired mobility, psychotropic drug use, history of falls, Dx (diagnoses) h/o (history of) CVA (stroke), limited mobility, h/o seizures, right sided weaked [sic], right fem-pop (1) surgical March 2016, and other comorbidities." This care plan was initiated on 6/10/16 and included the intervention of "Bed/chair alarm on at all times." This intervention was also initiated on 6/10/16. Further review of the care plan, as well as nurses notes, failed to reveal any concerns with the resident being non-compliant with the alarm.

On 6/30/16 at 4:30 p.m., the Administrator, Director of Nursing, and Corporate Nurse (ASM [Administrative Staff Member] #1, #2, and #3) were made aware of the findings. A policy for

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F 282	Continued From page 21 following the plan of care was requested; OSM #3 stated there isn't one. In addition, any documented evidence of the resident being non-compliant with the alarm was requested. None was provided by the end of the survey. According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders." (1) According to Johns Hopkins Medicine, a fem-pop (femoral popliteal) is a bypass surgery used to treat a blocked femoral artery. Information obtained from http://www.hopkinsmedicine.org/healthlibrary/test_procedures/cardiovascular/femoral_popliteal_bypass_surgery_92,P08294/	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to provide care and services to maintain the highest level of wellbeing for three of 24 residents in the survey sample, Resident #s 20, 1 and 9 1. The facility staff failed to administer morphine sulfate (1) to Resident #20 as ordered by the physician. 2. The facility staff failed to follow the physician orders and administer the full course of antibiotics to Resident #1 on two occasions, 3/26/16 and 4/9/16. 3. The facility staff failed to ensure communication and a coordinated plan of care between the facility and hospice provider for Resident #9. The hospice care plan and other hospice documentation were not available on Resident #9's clinical record as of 6/29/16 (seven days after the initiation of hospice services). The findings include: 1. The facility staff failed to administer morphine sulfate (1) to Resident #20 as ordered by the physician. Resident #20 was admitted to the facility on 8/25/214 with a readmission on 2/25/15 with diagnoses that included, but were not limited to; dementia, COPD (chronic obstructive pulmonary	F 309	F Tag 309: 1 & 2 Facility strives to follow physician orders and assure they are entered correctly. Residents #20 & #1. Resident #20 did not receive morphine as ordered. Resident #1 did not receive the full course of antibiotics. There were no negative outcomes for resident #20 or #1. Resident #20 was a hospice patient and expired. Physician was notified that the antibiotic course for Resident #1 was not fully administered. No new orders were received. All residents have the potential to be affected. The DON or designee will in-service licensed nurses on following physician orders and electronic order entry to ensure orders are correctly entered into the electronic health record.	

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F 309	Continued From page 23 disease - causes difficulty with breathing), high blood pressure and atrial fibrillation (irregular heart beat). Resident #20's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 2/26/16. Resident #20 was coded as a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was moderately cognitively impaired. A review of Resident #20's clinical record revealed, in part, the following telephone orders; 12/30/15, signed and dated by the physician on 1/5/16; " 12/30/15 Morphine (used to treat moderate to severe pain (1)) 20 mg (milligrams) / ml (milliliter) 0.25 ml Q3H prn (every three hours as needed) sob (shortness of breath)." 3/15/16, signed and dated by the physician on 3/15/16;"D/C (discontinue) morphine. Morphine 20 mg / ml give 0.25 ml (5 mg) po (by mouth) / sl (sublingual - beneath the tongue) q1 (one) hour prn (as needed) for pain / sob." Further review of Resident #20's clinical record revealed, in part, the following prescription renewal forms sent to the pharmacy to be filled; "(Name of Resident #20) Morphine 20 mg / ml 0.25 ml (5 mg) po q3 hrs (every three hours)." signed by the nurse practitioner and dated 3/14/16. "(Name of Resident #20) Morphine 20 mg / ml. 0.25 ml (5 mg) po / sl q1 hr (every one hour) prn (as needed) pain / sob." signed by the physician and dated 3/15/16. A review of Resident #20's physician order sheet	F 309	Two nurses will verify correct order entry. Administrative nurses will audit electronic orders in daily clinical operations meeting 5 times per week for 4 weeks. The results of the audits will be reviewed in the monthly quality assurance meeting with additional monitoring and education provided as needed. 3) The facility strives to ensure communication and a coordinated plan of care with the hospice provider for one resident. Resident #9 did not have a coordinated care plan initiated timely. The hospice care plan was received and placed on the medical record. All residents have the potential to be affected. DON or designee will check each newly admitted hospice medical record for the hospice care plan.	

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THE LAURELS OF BON AIR	**9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 24 of active orders dated 3/1/16 - 3/31/16 revealed, in part, the following documentation; "Start 12/30/15 End 2/28/17. Active recertified as of 2/29/16. Morphine Sulf (sulfate) 100 MG/5 ML soln (solution) 0.25 ML oral every 3 hours pain. Telephone order from (name of primary physician) taken by (name of nurse) noted on 12/30/15 7:11 p.m. by (name of nurse)." A review of Resident #20's MARs (medication administration records) dated January 2016, February 2016 and March 2016 revealed, in part, that Resident #20 was documented as receiving Morphine sulfate under the following order: "Morphine sulfate 100 mg /5 ml soln. 0.25 ml every 3 hours; oral for pain." Resident #20 received the medication one time each day at midnight between 1/1/2016 and 3/18/2018. Further review of Resident #20's January, February and March 2016, MARs revealed only one documented time (midnight) and one box below this time for administering and signing for the administration of the Morphine Sulfate ordered to be administered every three hours to Resident #20. There were no other boxes and times documented on the MARs for administering the Morphine Sulfate every three hours as ordered by the physician. Further review of Resident #20's clinical record did not reveal any documentation that Resident #20 had complaints of pain. On 6/30/16 at 9:25 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked to review the Morphine Sulfate order for Resident #20 and to explain what Resident	F 309	All hospice providers who provide services for the facility will be educated to have a plan of care in the medical record for each resident receiving services no later than 72 hours after admission to hospice services. The DON or designee will audit the process for compliance for 3 months. Variances will be reviewed in the monthly quality assurance meeting with additional monitoring provided as indicated. Completion date: July 29, 2016	

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#20 should have been administered from 1/1/16 to 3/18/16. ASM #2 reviewed the orders and stated that Resident #20 was to receive Morphine Sulfate every three hours. ASM #2 was asked whether or not Resident #20 was administered Morphine Sulfate every three hours, ASM #2 stated that he was not. ASM #2 further stated, "They (the nursing staff) put the order in wrong, it (the computer system) did not give them enough times to document. It was entered incorrectly so it would not have flagged to be given."

On 6/30/16 at approximately 12:30 p.m. a meeting was held with ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate nurse specialist. At this time the administrative staff present was made aware of the concerns. No further information was provided prior to the end of the survey.

(1) This information was obtained from the following website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682133.html

2. The facility staff failed to follow the physician orders and administer the full course of antibiotics to Resident #1 on two occasions, 3/26/16 and 4/9/16.

Resident #1 was admitted to the facility on 1/2/15 with diagnoses that included, but were not limited to; depression, anxiety, glaucoma (a disease of the eyes) heart disease, high blood pressure and dementia.

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Resident #1's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 5/10/16. Resident #1 was coded as a 7 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was moderately cognitively impaired.

A review of Resident #1's clinical record revealed, in part, two physician telephone orders that documented the following;
"3/26/16 - Z-Pak (An antibiotic used to treat bacterial infections, also called Azithromycin/ Zithromax (1)) as directed. Zithromax 500 mg (milligrams) x 1 (one) day (p.o.) (by mouth) then Zithromax 250 mg p.o. daily x 4 (four) days. Dx (diagnosis) URI (upper respiratory infection)." Signed and dated by the physician on 3/28/16.
"4/2/16 - Keflex (Also known as Cephalexin and is used to treat certain infections caused by bacteria such as pneumonia and other respiratory tract infections (2)) 500 mg po BID (two times a day) x 7 (seven) days. Dx UTI (urinary tract infection)." Signed and dated by the physician on 4/4/16.
Further review of Resident #1's clinical record revealed, in part, MARs (medication administration records) for March 2016 and April 2016, that evidenced the following documentation;
"Administration Record for period: 3/1/16 thru (sic) 3/31/16. Azithromycin 500 MG Tablet one tab (tablet) once per day, oral for upper respiratory infection. Start: 3/26/16 03:30 p.m. End: 03/26/16 11:59 p.m." The check off box for this medication on 3/26/16 was blank.
"Administration Record for period: 4/1/16 thru (sic) 4/30/16. Keflex 500 MG Capsule one cap (capsule) twice daily; oral for infection. Start: 4/2/16 05:21 p.m. End 4/8/16 11:59 p.m.

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F 309	Continued From page 27 Extended Directions for 7 (seven) days." The nurses initialed the following dates as given as instructed; 4/3/16; 4/4/16; 4/5/16; 4/6/16; 4/7/16/ and 4/8/16. Day 7, 4/9/16, was not initialed as given. On 6/30/16 at 8:40 a.m. an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the process for administering an antibiotic. LPN #2 stated, "We receive an order, enter it into the computer system for whatever date it should start and when it should end. We administer the medication as ordered by the physician." LPN #2 was asked if it was important to complete all days the antibiotic was prescribed for. LPN #2 stated, "When the medication is not given as ordered you should call the physician. If the guest (resident) does not get the full dose as ordered the infection may not be fully treated." On 6/30/16 at 11:20 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nurses. ASM #2 was shown the MARs and asked if Resident #1 had missed any doses of the antibiotics ordered in March and April. ASM #2 reviewed both MARs and stated, "The antibiotic ordered should be given as ordered. The loading dose of Azithromycin should have been administered and I see that it was not. The Keflex, (name of Resident #1) should have got this for 7 days, only documented as being given for 6 days." On 6/30/16 at approximately 12:30 p.m. a meeting was held with ASM #1, the administrator, ASM #2, the director of nurses, and ASM #3, the corporate clinical nurse. The above findings were provided. No further information was provided prior to the end of the survey process. (1) This information was obtained from the website:	F 309		

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https://www.nlm.nih.gov/medlineplus/druginfo/meds/a697037.html

(2)This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682733.html

3. The facility staff failed to ensure communication and a coordinated plan of care between the facility and hospice provider for Resident #9. The hospice care plan and other hospice documentation were not available on Resident #9's clinical record as of 6/29/16 (seven days after the initiation of hospice services).

Resident #9 was admitted to the facility on 3/4/16 with diagnoses that included but were not limited to anemia, high blood pressure, diabetes, thyroid disorder, anxiety, depression, and failure to thrive. Resident #9's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 3/4/16. Resident #9 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #9 was coded as requiring extensive assistance from staff with transfers, dressing, eating, toileting, and personal hygiene; and total dependence on staff with meals.

Review of Resident #9's clinical record revealed the following order initiated on 6/22/16, "Admit pt (patient) to (Name of Hospice) under the services of (Name of physician) and (Name of other physician) as HMD (Hospice Medical Doctor) Code Status DNR (Do not resuscitate)

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F 309	Continued From page 29 Activity Level: as tolerated Diet: as tolerated Cancel any lab or x-rays APP (Alternating Pressure) Mattress Morphine Sulfate (1) 20 mg (milligrams)/ml (milliliters) 0.25 ml po (by mouth)/ SL (sublingual: under tongue) q (every) 4 hours for pain prn (as needed) Ativan (2) 1 mg 1 tab (tablet) dissolve in water give po/sl q-8 hrs prn anxiety." This order was signed by the physician on 6/23/16. No hospice notes could be found regarding this visit with Resident #9 on the clinical record. The hospice care plan was also not on the clinical record for Resident #9. On 6/29/16 at approximately 2:15 p.m. the hospice care plan was requested from ASM (administrative staff member) #3, the corporate nurse. She stated, "The company probably has not sent it over yet. Hospice was initiated on 6/22/16 so it is probably not in the building yet. Medical Records are going to give them a call." On 6/30/16 at approximately 7:00 a.m., the hospice care plan was provided. A fax date at the top of the page documented the following: "06/29/16 at 4:39 p.m." On 6/30/16 at approximately 1 p.m., all hospice notes were requested from ASM (administrative staff member) #2, the Director of Nursing. She stated, "I will get those for you." On 6/30/16 at approximately 1:30 p.m., the hospice notes were provided. A fax date at the top of the notes documented the following: "06/30/16 at 08:15 a.m., " indicating the notes were just faxed over that day to the facility from	F 309		

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F 309	Continued From page 30 hospice. Review of the hospice notes revealed that the initial hospice evaluation was completed on 6/22/16 (when the care plan was developed), a hospice nurse had visited on 6/23/16, social work had visited on 6/24/16 and a hospice aide had visited on 6/28/16. The hospice care plan was not placed on the clinical record until 6/29/16 and the hospice notes were not placed on the clinical record until 6/30/16 when hospice faxed the notes over to the facility. Review of Resident #9's care plan created by the facility on 6/22/16 and updated on 6/27/16 under care area "Term ILL (Terminally Ill) documented in part, the following: "Refer to hospice plan of care." On 6/30/16 at 10:26 a.m., an interview was conducted with RN (Registered Nurse) #1, the hospice nurse. When asked the process of communication to the other nurses when hospice visits a resident, she stated that hospice will visit a resident and take notes on their own computer. Once hospice gets to their office, hospice staff will print the documentation and bring it with them to place on the resident's clinical record during the next visit. When asked if seven days is a long time for the care plan to be placed on the resident's clinical record she stated, "I think so, but I'm also new and learning the process. Usually 5-6 days we bring the care plan back." When asked how facility staff is supposed to know what is going with the resident if there are no notes on the clinical record from hospice she stated that hospice gives a verbal report to the nurse working on duty.	F 309		

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F 309	Continued From page 31 On 6/30/16 at 4:11 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #8. She stated that hospice will give a verbal report to the facility nurses when they visit a resident. When asked if notes or a care plan from hospice should be placed on the clinical record for continuity of care, LPN #8 stated, "I would say yes." On 6/30/16 at approximately 1:00 p.m., an interview was conducted with ASM (administrative staff member) #2. When asked how facility staff is supposed to know what is going on with residents receiving hospice services if notes are not placed on the clinical record from the hospice company, ASM #2 stated that nursing gets a verbal report from hospice. When asked how the facility determines a cordinated plan of care for a resident receiving hospice services if the care plan from the hospice company is not placed on the clinical record, ASM #2 stated that hospice will give a verbal report to the facility and then the facility will develop their own care plan. She stated that seven days was a reasonable time for the facility to receive the hospice care plan from the company. Review of the hospice contract from (name of hospice company) for Resident #9 documents in part, the following: "HOSPICE shall provide FACILITY with a copy of the Hospice plan of care specifying the Residential Services that FACILITY will furnish. HOSPICE shall document in the patient's record that this requirement has been met...Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of the Hospice Patient are met...Hospice shall promote open and frequent communication with FACILITY and shall	F 309		

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F 309	Continued From page 32 provide FACILITY with sufficient information to ensure that the provision of Residential Services under this agreement is in accordance with the Hospice plan of care, assessments, treatment planning and care coordination." No further information was provided prior to exit. (1) Morphine Sulfate- opioid analgesic used to minimize severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 843. (2) Ativan-depresses the central nervous system to decrease anxiety or used as a sedative. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 763.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide an environment free of accidents and hazards for 1 of 24 residents in the survey sample; Resident #12. For Resident #12, the facility staff failed to ensure	F 323		

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F 323	Continued From page 33 a clip alarm was on at all times for the prevention of falls. The findings include: Resident #12 was admitted to the facility on 6/8/16 with the diagnoses of but not limited to high blood pressure, coronary artery disease, atrial fibrillation, shortness of breath, seizures, bladder spasms, neurogenic bladder, and a suprapubic catheter. The most recent MDS (Minimum Data Set) was an admission MDS with an ARD (Assessment Reference Date) of 6/15/16. The resident was coded as severely cognitively impaired in ability to make daily life decisions, scoring a 7 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for transfers and hygiene; limited assistance for dressing and ambulation; and supervision for eating. The resident was coded as having no range of motion limitations of upper and lower extremities. A review of the clinical record revealed a physician's order dated 6/8/16 for "Safety Alarm: Sensor Alarm to Bed/Chair. Check placement and function every shift." On 6/28/16 at 2:52 p.m., an observation was made of Resident #12. He was in his wheelchair in his room next to his bed (window bed) and next to him was a regular chair. He was turned around in his wheelchair, removing the clip alarm box hanging on the left handle of the wheelchair. Next he was fidgeting with the alarm and then laid it down in the regular chair next to him. He was	F 323	F Tag 323: The facility strives to provide an environment free of accidents and hazards. Resident #12 did not have a clip alarm on at all times for prevention of falls. A sensor alarm replaced the clip alarm for Resident #12. All residents have the potential to be affected. Licensed nurses will verify placement of clip alarms and sign the electronic health record for documented compliance. Staff members will be educated on the facility fall awareness program to include placement of clip alarms	

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F 323	Continued From page 34 then observed to get up out of the wheelchair, pivot, and sit on the bed. The alarm did not go off because there was too much slack in the cord from the clip attached to him to where the alarm was laying in the regular chair. By Resident #12 moving the alarm box, it ensured the alarm was closer to the bed and would not pull at the clip attached to him and activate the alarm. Resident #12 was then observed sitting on the bed and making phone calls. After a few minutes, he picked the alarm box up off the regular chair, and put it in his jacket pocket, further making the alarm less likely to be activated. At 3:00 p.m., CNA #2 (Certified Nursing Assistant) entered the resident's room, went all the way into the room near Resident #12, looked at Resident #12 and looked at his roommate, and left the room. She did not notice the alarm was not placed in any manner that would activate it if the resident had a fall, and did not correct the situation to ensure the alarm was being worn in a manner that would make it functional. On 6/30/16 at 10:30 a.m., Resident #12 was observed up in his wheelchair in his room near the door to the room. His clip alarm was not on. An observation of the resident's bed area failed to reveal where the clip alarm was at this time. Therapy staff was in the room with the roommate. On 6/30/16 at 3:39 p.m., an observation was made of Resident #12 sitting in his wheelchair in the therapy room. He was at the table, not doing any activities. His clip alarm was not on. On 6/30/16 at 3:55 p.m., an observation was made of Resident #12 in his wheelchair in the hallway. The clip alarm was on at this time. At this time, an interview was conducted with OSM	F 323	according to guest care plans. A list of residents with alarms will be provided for staff members to ensure compliance. The DON or designee will conduct random audits of residents with clip alarms to verify compliance, 3 times per week for 4 weeks. Variances identified will be reviewed in the monthly quality assurance meeting with additional monitoring and education provided as needed. Completion date: July 29, 2016	

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F 323	Continued From page 35 #5 (Other Staff Member), the physical therapist, that was in the hallway near Resident #12. OSM #5 was asked about the clip alarm and informed of the observation of the alarm not in place on the resident 20 minutes earlier, in the therapy room. OSM #5 was asked if she knew anything about when the clip alarm was put on Resident #12. OSM #5 stated she did know because she was present when the nurse came and put it on him (LPN #7 - Licensed Practical Nurse). On 6/30/16 at 3:58 p.m., an interview was conducted with LPN #7. She stated that the resident is supposed to have it on at all times but that he is non-compliant with it. A review of the care plan revealed one for "Falls: At risk for fall related injury related to: Unsteady gait, impaired mobility, psychotropic drug use, history of falls, Dx (diagnoses) h/o (history of) CVA (stroke), limited mobility, h/o seizures, right sided weaked [sic], right fem-pop (1) surgical March 2016, and other comorbidities." This care plan was initiated on 6/10/16 and included the intervention of "Bed/chair alarm on at all times." This intervention was also initiated on 6/10/16. Further review of the care plan, as well as nurses notes, failed to reveal any concerns with the resident being non-compliant with the alarm. A review of the facility policy, "Falls Awareness Program" did not readily address the prevention of falls (i.e., interventions and methods, etc.) beyond assessing and identifying those who are at risk. On 6/30/16 at 4:30 p.m., the Administrator, Director of Nursing, and Corporate Nurse (ASM	F 323		

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[Administrative Staff Member] #1, #2, and #3) were made aware of the findings. No further information was provided by the end of the survey.

In "Fundamentals of Nursing" 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 5. "Client safety is a priority in health care. You need to protect clients from physical and emotional injury by continually assessing for and eliminating safety hazards. Clients fall due to many factors, such as improper transfer techniques, client age, side effects of medications, impaired mobility, or confusion. Learn your agency's fall prevention program for reducing client falls. Programs that use a multidimensional approach in designing fall prevention strategies have the greatest reduction in fall rates."

According to "Handbook of Nursing Procedures Springhouse Corporation 2006 pages 323 through 328- Fall Prevention and Management: Falls are a major cause of injury and death among elderly people...an alarm system can be used to prevent falls...the system adapts to a bed or chair...the alarm sounds when the patient attempts to stand or transfer themselves unassisted..."

(1) According to Johns Hopkins Medicine, a fem-pop (femoral popliteal) is a bypass surgery used to treat a blocked femoral artery. Information obtained from http://www.hopkinsmedicine.org/healthlibrary/test_procedures/cardiovascular/femoral_popliteal_bypass_surgery_92,P08294/

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	495394	A. BUILDING ______ B. WING ______	C 06/30/2016

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F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure medication administration pass was free from significant medication errors for one of five residents in the medication administration observation, Resident #1.	F 333	F Tag 333: The facility strives to ensure medication administration passes are free from errors. Resident #1 received a medication in crushed form that was not on the Do Not Crush list. No negative outcomes resulted. LPN #2 was immediately provided with additional training regarding the "Do Not Crush List".	
	1) Facility staff crushed the medication Klon Clor 20 MEQ (potassium supplement (1)) extended release during medication administration observation and failed to safely administer the medication to Resident #1. The findings include: Resident #1 was admitted to the facility on 1/2/15 with diagnoses that included but were not limited to atrial fibrillation, high blood pressure, arthritis, osteoporosis, Non-Alzheimer's Dementia, anxiety disorder and depression. Resident #1's most recent MDS (minimum data set) was a significant change MDS with an ARD (assessment reference date) of 5/10/16. Resident #1 was coded as being severely cognitively impaired in the ability to make daily life decisions scoring 7 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring extensive assistance from staff with transfers, dressing, eating, toileting		All residents have the potential to be affected. The DON or designee will re-educate all licensed nurses on the "Do Not Crush List" located on the medication cart for reference. The 5 rights of medication administration will be reviewed to include physician notification for residents unable to tolerate the	

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and personal hygiene, and total dependence on staff with bathing.

On 6/29/16 at 7:55 a.m., medication administration observation was conducted. At 7:55 a.m., LPN (Licensed practical nurse) # 2 prepared the following medications for Resident #1:
Tramadol (2) 3 half tablets to =75 mg (milligrams)
Restasis (3) 0.05 percent - 1 gtt (drop) to both eyes
Flecaintide acetate (4) 50 mg- 1 tablet
Lasix (5) 20 mg - 1 tablet
Losartan Potassium (6) 25 mg -1 tablet
prednisone (7) 2.5 mg- 1 tablet
Zoloft HCL (hydrochloride) (8) 100 mg - 1 tablet
Klon Chlor (1) 20 MEQ (Milliequivlants)- 1 tablet

At 8:09 p.m., LPN #2 crushed all medications together including the Klon Chlor and added applesauce to the medication cup. She walked over to Resident #1 who was sitting in the hallway behind the medication cart and administered the medication to the resident.

On 6/29/16 at 8:36 a.m., an interview was conducted with LPN #2. When asked if potassium supplements were allowed to be crushed she stated, "Not sure." LPN #2 checked the "DO NOT CRUSH MEDICATION LIST on the medication cart and it documented the following: "Common Oral Dosage Forms that Should Not be Crushed...Potassium chloride...extended release." LPN #2 stated, "Some residents have orders that it may be crushed. She may have orders. I can go check."

Review of Resident #1's POS (physician order sheet) dated 5/30/16 did not reveal an order to

prescribed method ordered to obtain a change.

The DON or designee will conduct random medication pass observations weekly for 4 weeks to ensure compliance.

Variances identified will be reviewed in the monthly quality assurance meeting with additional monitoring and education provided as needed.

Completion date:
July 29, 2016

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F 333	Continued From page 39 crush her potassium supplement.	F 333		

Review of Resident #1's potassium levels dated 5/9/16 revealed that her potassium level was within normal range.

On 6/30/16 at 10:00 a.m., an interview was conducted with LPN #8. When asked how to administer potassium chloride to a resident who cannot swallow medications whole she stated, "Call the doctor to get an order for the potassium in liquid form or another form." LPN #8 stated that potassium was extended release and cannot be crushed. When asked if the doctor has ever wrote an order to crush a potassium tablet she stated, "Not that I am aware of."

On 6/30/16 at 10:15 a.m., an interview was conducted with LPN #1. LPN #1 stated, "You cannot crush potassium. You would have to call pharmacy to get potassium in a different form." She stated that crushing potassium interferes with absorption.

On 6/29/16 at 5:45 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the corporate nurse was made aware of the above findings.

Facility policy titled, "Medication Administration" did not address the administration of potassium.

No further information was presented prior to exit.

(1) Klon Chlor 20 MEQ-used as a supplement for the prevention of potassium deficiency. "NOTE: Potassium chloride extended-release tablets are to be swallowed whole without crushing, chewing

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F 333	Continued From page 40 or sucking the tablets." This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 997. (2) Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 1197. (3) Restasis- Used to increase tear production in those with dry eye disease. This information was obtained from the National Institutes of Health. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a604009.html. (4) Flecaintide acetate- used to prevent certain types of life threatening irregular heartbeat. This information was obtained from The National Institutes of Health. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a608040.html. (5) Lasix 20 mg- used to decrease edema (excess fluid) in patients with heart failure, liver impairment or kidney disease. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 587. (6) Losartan Potassium- Used to decrease blood pressure. This information was obtained from The National Institutes of Health. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a695008.html. (7) Prednisone 2.5 mg-corticosteroid used to suppress inflammation and the normal immune response. This information was obtained from Davis's Drug Guide for Nurses, 11th edition. p. 351.	F 333		

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F 333	Continued From page 41 (8) Zoloft HCL 100 mg-antidepressant that is also used to treat generalized anxiety disorder. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 1103.	F 333		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that facility staff failed to maintain a complete and accurate clinical record for three of 25 residents in the survey sample; Resident #6, #9, and #4. 1. The facility staff failed to ensure a complete MAR (Medication Administration Record) for the months of April and June 2016 for Resident #6. 2. The facility staff failed to ensure the hospice notes and care plan were placed on the clinical record for Resident #9.	F 514		

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F 514	Continued From page 42 3. The facility staff failed to ensure that Resident #4's clinical record did not include another resident's documentation. The findings include: 1. Resident #6 was admitted to the facility on 3/28/16 with diagnoses that included but were not limited to high blood pressure, thyroid disorder, stroke, one sided paralysis, aphasia (1), difficulty in walking and muscle weakness. Resident #6's most recent MDS (Minimum Data Set) was a 60 day scheduled assessment with an ARD (Assessment Reference Date) of 5/26/16. Resident #6 was coded as being moderately impaired in cognitive status on the staff assessment for mental status exam. Resident #6 was coded as requiring extensive assistance from staff with transfers, dressing, toileting, and personal hygiene; and total dependence on staff with bathing. Review of Resident #6's April and June 2016 MAR (Medication Administration Record) revealed no electronic signatures for the following medications: "Baclofen (2) 10 MG (milligram) tablet on 4/7/16 at 2:00 p.m., 4/12/16 at 10:00 p.m., 4/17/16 at 10:00 p.m., 4/18/16 at 2:00 p.m., 4/20/16 at 10:00 p.m. and 6/18/16 at 2:00 p.m." Enteral Water Flushes (3) 6 times a day...200 ml (milliliter) flushes, q (every) four hrs (hours) on 4/7/16 at 2:00 p.m., 4/12/16 at 10:00 p.m., 4/17/16 at 10:00 p.m., 4/18/16 at 2:00 p.m. and 6/18/16 at 2:00 p.m."	F 514	F Tag 514: 1) The facility strives to ensure a complete medication administration record. Resident #6 had an incomplete record for April and June. No negative outcomes resulted. Education was provided to the LPN to verify administration of medications on the electronic health record. All residents have the potential to be affected. DON or designee will educate all licensed nurses to check the medication administration record for accuracy after each medication pass by completing a missed medication report. The missed medication reports will be reviewed in the clinical operations meeting 5 times per week for 4 weeks to verify accuracy.	

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F 514	Continued From page 43 Review of the April and June 2016 nursing notes revealed no documentation related to the missing signatures on the above MARS. On 6/30/16 at 10:25 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #5, regarding what blanks mean on the MAR. LPN #5 stated that the medication was either not given or just not signed off on the MAR. She stated that often administration will do audits to check for holes in the MARS. LPN #5 stated that nursing is expected to correct holes (blanks) in the MAR. She stated that if the medication was not given then a note should be written documenting the reason. LPN #5 confirmed that no documentation could be found related to the missing signatures on the above MARs for Resident #6. On 6/30/16 at 10:36 a.m., an interview was conducted with LPN #7. When asked what blanks meant on the MAR, LPN #7 stated that the nurse probably forgot to sign off that the medication was given. She also stated that administration will do frequent audits to monitor holes or blanks on the MAR. LPN #7 stated that the nurse responsible for most of the blanks on the April 2016 MAR was on vacation at that time. This nurse could not be reached for an interview. On 6/30/16 at approximately 1:00 p.m., ASM (administrative staff member #2, the DON (Director of Nursing), and ASM #3, the corporate nurse were made aware of the above findings. Facility policy titled, "Medical Records Chart Analysis" documents in part, the following: "In order to maintain the clinical record in its most complete and useful form as well as to ensure	F 514	Variances identified will be reviewed in the monthly quality assurance meeting with additional monitoring provided as needed. 2) The facility strives to ensure that hospice notes and a care plan are placed on the clinical record for hospice residents. Resident #9 did not have their hospice notes or care plan on the record. No negative outcome resulted. The hospice care plan was immediately placed on the medical record. All residents have the potential to be affected. All hospice providers who provide services to the facility will be educated to have a plan of care in the residents' medical record within 72 hours after admission to hospice services. The DON or designee will audit this process monthly for 3 months for compliance.	

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accuracy, and regulatory compliance, each clinical record should be reviewed on a regular basis. Each record should contain required and appropriate information to verify accurate, complete, and timely entries, which are dated and signed by the appropriate staff."

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice.
Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

(1) Aphasia-"a disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say." This information was obtained from The National Institutes of Health. https://www.nlm.nih.gov/medlineplus/aphasia.html.

(2) Baclofen-skeletal muscle relaxant used to decrease muscle spasticity. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 213.

(3) Enteral Water Flushes- "Enteral feeding is used to feed patients who cannot attain an adequate oral intake from food and/or oral nutritional supplements, or who cannot eat/drink

F 514

Variances identified will be reviewed in the monthly quality assurance meeting with additional monitoring provided as needed.

3)
The facility strives to ensure accuracy and HIPAA compliance with medical records. Resident #4 had some documents of another residents' in their chart.
Nursing administration and medical records completed a 100% audit of medical records for compliance of a complete medical record.

All residents have the potential to be affected.

The DON or designee will educate all licensed nurses to ensure complete and accurate records are maintained with proper filing of documentation.

Medical records designee will conduct an audit weekly for 4 weeks for compliance and randomly thereafter.

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F 514	Continued From page 45 safely. The aim is to improve nutritional intake and so improve or maintain nutritional status...A tube is placed into the stomach or intestines usually by the nose, mouth or directly through the skin...Flushes prevent clogging of the feeding" This information was obtained from the National Institutes of Health http://www.ncbi.nlm.nih.gov/books/NBK49253/. 2. The facility staff failed to ensure the hospice notes and care plan were placed on the clinical record for Resident #9. Resident #9 was admitted to the facility on 3/4/16 with diagnoses that included but were not limited to anemia, high blood pressure, diabetes, thyroid disorder, anxiety, depression, and failure to thrive. Resident #9's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 3/4/16. Resident #9 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #9 was coded as requiring extensive assistance from staff with transfers, dressing, eating, toileting, and personal hygiene; and total dependence on staff with meals. Review of Resident #9's clinical record revealed the following order initiated on 6/22/16, "Admit pt (patient) to (Name of Hospice) under the services of (Name of physician) and (Name of other physician) as HMD (Hospice Medical Doctor) Code Status DNR (Do not resuscitate) Activity Level: as tolerated Diet: as tolerated	F 514	Variances identified will be reviewed in the monthly quality assurance meeting with additional monitoring provided as needed. Completion date: July 29, 2016	

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F 514	Continued From page 46 Cancel any lab or x-rays APP (Alternating Pressure) Mattress Morphine Sulfate (1) 20 mg (milligrams)/ml (milliliters) 0.25 ml po (by mouth)/ SL (sublingual: under tongue) q (every) 4 hours for pain prn (as needed) Ativan (2)1 mg 1 tab (tablet) dissolve in water give po/sl (by mouth/sublingual) q-8 hrs (every eight hours) prn anxiety." This order was signed by the physician on 6/23/16. No hospice notes could be found regarding this visit with Resident #9 on the clinical record. The hospice care plan was also not on the clinical record for Resident #9. On 6/29/16 at approximately 2:15 p.m. the hospice care plan was requested from ASM (administrative staff member) #3, the corporate nurse. She stated, "The Company probably has not sent it over yet. Hospice was initiated on 6/22/16 so it is probably not in the building yet. Medical Records are going to give them a call." On 6/30/16 at approximately 7:00 a.m., the hospice care plan was provided. A fax date at the top of the page documented the following: "06/29/16 at 4:39 p.m." On 6/30/16 at approximately 1 p.m., all hospice notes were requested from ASM (administrative staff member) #2, the Director of Nursing. She stated, "I will get those for you." On 6/30/16 at approximately 1:30 p.m., the hospice notes were provided. A fax date at the top of the notes documented the following: "06/30/16 at 08:15 a.m.," indicating the notes were just faxed over that day to the facility from hospice.	F 514		

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F 514	Continued From page 47 Review of the hospice notes revealed that the initial hospice evaluation was completed on 6/22/16 (when the care plan was developed), a hospice nurse had visited on 6/23/16, social work had visited on 6/24/16 and a hospice aide had visited on 6/28/16. The hospice care plan was not placed on the clinical record until 6/29/16 and the hospice notes were not placed on the clinical record until 6/30/16 when hospice faxed the notes over to the facility. On 6/30/16 at 10:26 a.m., an interview was conducted with RN (Registered Nurse) #1, the hospice nurse. When asked the process of communication to the other nurses when hospice visits a resident, she stated that hospice will visit a resident and take notes on their own computer. Once hospice gets to their office, hospice staff will print the documentation and bring it with them to place on the resident's clinical record during the next visit. When asked if seven days is a long time for the care plan to be placed on the resident's clinical record she stated, "I think so, but I'm also new and learning the process. Usually 5-6 days we bring the care plan back." When asked how facility staff is supposed to know what is going with the resident if there are no notes on the clinical record from hospice she stated that hospice gives a verbal report to the nurse working on duty. On 6/30/16 at 4:11 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #8. She stated that will give a verbal report to the facility nurses when they visit a resident. When asked if notes or a care plan from hospice should be placed on the clinical record for continuity of care, LPN #8 stated, "I would say yes."	F 514		

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F 514	Continued From page 48 On 6/30/16 at approximately 1:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked how facility staff is supposed to know what is going on with residents receiving hospice services if notes are not placed on the clinical record from the hospice company, ASM #2 stated that nursing gets a verbal report from hospice. When asked how the facility determines the plan of care for a resident receiving hospice services if the care plan from the hospice company is not placed on the clinical record, ASM #2 stated that hospice will give a verbal report to the facility and then the facility will develop their own care plan. ASM #2 stated that seven days was a reasonable time for the facility to receive the hospice care plan from the company. Review of the hospice contract from (name of hospice company) for Resident #9 documents in part, the following: "HOSPICE shall provide FACILITY with a copy of the Hospice plan of care specifying the Residential Services that FACILITY will furnish. HOSPICE shall document in the patient's record that this requirement has been met...Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of the Hospice Patient are met...Hospice shall promote open and frequent communication with FACILITY and shall provide FACILITY with sufficient information to ensure that the provision of Residential Services under this agreement is in accordance with the Hospice plan of care, assessments, treatment planning and care coordination." No further information was provided prior to exit.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING ______ B. WING ______	C 06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

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F 514	Continued From page 49 (1) Morphine Sulfate- opioid analgesic used to minimize severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 843. (2) Ativan-depresses the central nervous system to decrease anxiety or used as a sedative. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 763. 3. The facility staff failed to ensure that Resident #4's clinical record did not include another resident's documentation. Resident #4 was admitted to the facility on 8/15/14 with diagnoses that included, but were not limited to; hypothyroidism (low thyroid function), high blood pressure, atrial fibrillation (an irregular heartbeat), glaucoma (a disease of the eyes), aortic stenosis (a disease of the main artery to the heart), and dementia. Resident #4's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/28/16. Resident #4 was coded as a five out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was severely cognitively impaired. On 6/29/16 at approximately 9:30 a.m. a review of Resident #4's clinical record revealed two documents belonging to another resident (Resident #9). The documents were an OT (occupational therapy) order and a supply order sheet. On 6/29/16 at 9:45 a.m. an interview was conducted with LPN (licensed practical nurse) #2, the floor nurse. LPN #2 was asked who was responsible for placing documents into the clinical	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 50 record. LPN #2 stated that the nurses put the physician order sheets, telephone orders and the narcotic sheets into the record and she did not know who else placed documents into the record. LPN #2 was shown the two documents belonging to Resident #9 that were in Resident #4's record. LPN #2 was asked if (name of Resident #9's) paperwork should be in Resident #4's clinical record. LPN #2 stated, "No they are in the wrong chart." On 6/29/16 at 9:50 a.m. an interview was conducted with ASM (administrative staff member) #4, the assistant director of nursing. ASM #4 was shown Resident #4's clinical record to verify that Resident #9's documentation was in the wrong chart. ASM #4 reviewed and confirmed that it was. ASM #4 stated, "It should not be in there, I will take care of this right now." An end of day meeting was held on 6; /29/16 at 5:10 p.m. with ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate clinical specialist. The staff was made aware at this time of the above findings. No other information was provided prior to the end of the survey process.	F 514		