PRINTED: 07/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495394	B. WING	3	06	C 3 <b>/30/2016</b>
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
	survey was conducted Corrections are recompleted to the corrections are recompleted to the corrections are recompleted to the consisted of 19 cures (Residents #1 throwall #18 through #22). 483.10(e), 483.75(PRIVACY/CONFIDE The resident has the confidentiality of his records.  Personal privacy in medical treatment, communications, preetings of family does not require the room for each resident release of personal individual outside to the resident is transferited.	Medicare/Medicaid standard sted 6/28/16 through 6/30/16. quired for compliance with 42 eral Long Term Care Life Safety Code survey/report  124 bed certified facility was e survey. The survey sample rent resident reviews ugh #17 and Residents #23-ed record reviews (Residents  I)(4) PERSONAL DENTIALITY OF RECORDS  The right to personal privacy and sor her personal and clinical eresonal care, visits, and and resident groups, but this personal care, visits, and and resident groups, but this personal care of the facility to provide a private dent.  Id in paragraph (e)(3) of this not may approve or refuse the all and clinical records to any		The Laurels of Bon wishes to have this submiplan of correction stand a allegation of compliance. date of alleged compliance July 29, 2015.  Preparation and/or exect of this plan of correction not constitute admission nor agreement with, either existence of or the scope severity of any of the deficiencies, or conclus set forth in the statement deficiencies. This plat prepared and/or execute ensure continuing complimite with regulatory requirement.  Frag 164:  1)  Facility staff strives to maintain visual privacy was administering medication one resident. Resident # not have full visual privacy during medication administration. Education was immediately provided LPN #2.	otted s its Our ce is otion does to, r the and cited sions n t of n is d to ance ents.	
LARORATOR	HADRACTOR'S AR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	MATLIDE	TITLE	<del> </del>	(X6) DATE

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

program participation.

AND DIVINGE CORRECTION INCLUDING INC		E CONSTRUCTION	COMPLETED				
		495394	B. WING			ì	⊃ 30/2016
	PROVIDER OR SUPPLIER JRELS OF BON AIR			9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 164	contained in the re the form or storage release is required	eep confidential all information esident's records, regardless of emethods, except when by transfer to another on; law, third party payment	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 time	S.	
	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				The DON or designee will educate all licensed nurses regarding maintaining full visual privacy during medication administration.		
	<ul><li>23); and for one o sample; (Resident</li><li>1) Facility staff fail when administerin</li><li>2) During medicat facility staff failed</li></ul>	ed to maintain full visual privacy ng Resident #1's medications. ion administration observation, to properly dispose of patient			On-going compliance will monitored through review quarterly medication pass observations. Additional education and monitoring be initiated for any identificoncerns.	of will	
	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.				Variances will be reviewed in the monthly quality assurance meeting with additional monitoring and education provided as needed.		
	set) was a signific	st recent MDS (minimum data cant change MDS with an ARD					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l .	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		495394	B. WING		1	C / <b>30/2016</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235			
(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 CORRECT (EACH CORRECTIVE ACTION SHO'CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 164	Resident #1 was co cognitively impaired decisions scoring? Interview for Menta was coded as required from staff with trainand personal hygiestaff with bathing.  On 6/29/16 at 7:55 administration obst LPN (Licensed pra LPN # 2 prepared medications for Resident and Potassis (2) 0.05 eyes Flecaintide acetat Lasix (4) 20 mg - Losartan Potassis prednisone (6) 2.5 Zoloft HCL (hydrot Klon Chlor (8) 20 M At 8:09 p.m., LPN together and addecup. She walked consisting in the hallwanext to two other materials (1) administered the hallway. LPN permission to give On 6/29/16 at 8:36 conducted with LP	oded as being severely d in the ability to make daily life out of 15 on the BIMS (Brief al Status) exam. Resident #1 siring extensive assistance sfers, dressing, eating, toileting ene, and total dependence on a.m., a medication ervation was conducted with actical nurse) # 2. At 7:55 a.m., and administered the following esident #1:  f tablets to =75 mg (milligrams) percent - 1 gtt (drop) to both e (3) 50 mg- 1 tablet 1 tablet um (5) 25 mg -1 tablet		Facility staff strives to properly dispose of patient sensitive information print on the medication packet when discarding the packet in the trash. Residents #1 #23 & #24 had patient sensitive information on medication packets throw away without proper disposal of the medication was given to more 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 pill packets by ablation of names.  All licensed nurses will be educated regarding dispose medication packets provide confidentiality of patient information by ablation of name prior to disposal.	ets , #4,  n osal. urses		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	(X3) DATE SURVEY COMPLETED		
		495394	B. WING_		C 06/30/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/30/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION
F 164	she stated that nur their rooms. Wher permission to give to Resident #1 she On 6/30/16 at 10:0 conducted with LP maintain privacy w to residents, she s their rooms with th "They are not supphallway."  On 6/30/16 at 10:1 conducted with LP maintain privacy a medications she sithe resident to their to give it in a public medication. She smedications in public medications in public medications in public medication in public medic	ses should take the resident to a sked if she asked the medications in the hallway stated, "I didn't."  0 a.m., an interview was N #8. When asked how to hen administering medications tated that residents must be in e curtain pulled. She stated, bosed to be given in the  5 a.m., an interview was N #1. When asked how to addignity when administering tated that nurses should take in room or ask them permission to place prior to giving the stated that administering olic without permission is a stated, "Some patients may redications in the hallway."  5 p.m., ASM (administrative the administrator, ASM #2, the Nursing), and ASM #3, the as made aware of the above  1, "Medication Administration" e above concerns.  Ition was presented prior to exit.	F 16	Random audits for compliance after medicati administration will be conducted for compliance times per month for 3 more variances will be reviewed in the monthly quality assurance meeting with additional monitorin and education provided as needed.  Completion date: July 29, 2016	nths.
	standards for wha	ion, page 414; "Nursing t constitutes confidentiality used on professional ethics and			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495394	B. WING	i		t	30/2016
	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 1101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/	30,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 164	the common law. sensitivity to the n may not choose to	The ideals of privacy and eeds and rights of clients who have nurses intrude on their end on nurses for their care,	F	164			
	severe pain. This Davis's Drug Guid 1197.  (2) Restasis- Used those with dry eye obtained from the	algesic used to treat moderate to information was obtained from the for Nurses, 11th edition p.  d to increase tear production in a disease. This information was National Institutes of Health.			•		
	ds/a604009.html.  (3) Flecaintide acc types of life threat information was o Institutes of Healt	etate- used to prevent certain tening irregular heartbeat. This obtained from The National h. uth.gov/medlineplus/druginfo/me					
	(excess fluid) in p impairment or kid was obtained fron Nurses, 11th editi	·		•	·		
7.7	pressure. This in The National Insti	nih.gov/medlineplus/druginfo/me					
		5 mg-corticosteroid used to nation and the normal immune					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495394	B. WING				C 30/2016
	PROVIDER OR SUPPLIER			91	REET ADDRESS, CITY, STATE, ZIP CODE 01 BON AIR CROSSINGS DRIVE ON AIR, VA 23235		0012010
(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 APPROFEDERICIENCY)	D BE	(X5) COMPLETION DATE
F 164	response. This info	age 5 ormation was obtained from e for Nurses, 11th edition, p.	F	164			
	used to treat general information was ob-	mg-antidepressant that is also ralized anxiety disorder. This otained from Davis's Drug 11th edition, p. 1103.				,	
	the prevention of p information was ob	MEQ-used as a supplement for otassium deficiency. This otained from Davis's Drug 11th edition, p. 997.					
	observation, facility of patient sensitive medication packet	lication administration y staff failed to properly dispose e information printed on the s by throwing the packets into or Resident #1, #4, #18 and	3				
	with diagnoses that to atrial fibrillation, osteoporosis, Non disorder and deprerecent MDS (minir change MDS with date) of 5/10/16. It being severely cogmake daily life dec	admitted to the facility on 1/2/15 at included but were not limited high blood pressure, arthritis, -Alzheimer's Dementia, anxiety ession. Resident #1's most mum data set) was a significant an ARD (assessment reference Resident #1 was coded as gnitively impaired in the ability to cisions scoring 7 out of 15 on terview for Mental Status)					
		admitted to the facility on gnoses that included but were					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				COMPLETED		
		495394	B. WING			0	C 06/30/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 164	not limited to high to cholesterol, Non-Apsychotic disorder. MDS (minimum datassessment with a date) of 4/28/16. Five being severely cogmake daily decision BIMS (Brief Interviolement of the being severely cogmake daily decision BIMS (Brief Interviolement of the being severely cogmake daily decision BIMS (Brief Interviolement of the bims of the bims.  On 6/29/16 at 7:55 administration obs LPN (Licensed praises of the bims.	plood pressure, high zheimer's Dementia, and Resident #4's most recent ta set) was a quarterly n ARD (assessment reference desident #4 was coded as nitively impaired in the ability to ns scoring 5 out of 15 on the ew for Mental Status) exam.  admitted to the facility on oses that included but were not done pressure, high cholesterol, zheimer's dementia.  ost recent MDS (minimum data y assessment with an ARD ence date) of 6/16/16.  coded as being severely done in the ability to make daily life a out of 15 on the BIMS (Brief al Status) exam.  admitted to the facility on oses that included but were not illation, high blood pressure, bementia, difficulty in walking, ness. Resident #24's most num data set) was an ment with an ARD of 6/23/16. In second of the second o		164				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 164	Tramadol 3 half tal Restasis 0.05 pero Flecaintide acetate Lasix 20 mg - 1 ta Losartan Potassiu prednisone 2.5 mg Zoloft HCL (hydrod Klon Chlor 20 MEC At 8:00 a.m., after the cup, she threw the regular trash the package. The pill package.  On 6/29/16 at 8:15 preparing the follow # 23:  Aspirin (9) 81 mg-Norvasc (10) 10 m Plavix (11)75 mg - At 8:20 a.m., after the cup, she threw regular trash that it package. The nar package.  On 6/29/16 at 8:21	plets to =75 mg (milligrams) cent - 1 gtt (drop) to both eyes e 50 mg- 1 tablet blet m 25 mg-1 tablet - 1 tablet chloride) 100 mg - 1 tablet Q (Milliequivlants)- 1 tablet LPN #2 popped each pill into away both pill packages into nat had the resident's name on name was not ablated off the p.m., LPN #2 was observed wing medications for Resident 1 tablet g - 1 tablet	F 1	164			
	Norvasc 10 mg- 1 Flecaintide acetate Lipitor (12) 10 mg Colace (13) 100 m Ocuvite Lutein (14 Namenda (15)28 i	e 50 mg- 1 tablet - 1 tablet ·g - 1 tablet ) - 1 tablet					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  JRELS OF BON AIR			91	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 164	Continued From p Spironlactalone (1	_	F	164			
	administered Resi threw away the pill with Resident #4's	dent #4's medications she package into the regular trash name still attached to the nt #4's name was not ablated					
	conducted with LF medication cart tra is completed, she soiled utility room asked where patie documents with rediscarded she sta shredder box. Wi away pill package attached to the pausually discard the	o a.m. an interview was IN #2. When asked where the ash goes after medication pass stated that trash went into the at the end of each shift. When ant sensitive items such as esidents' name on them go to be ted that the facility had a nen asked if it was ok to throw is with the residents' names still ckage, LPN #2stated, "Yes, we sem in the trash but we try to rip and place it all in the trash."					
	medication cart or conducted. A pill regular trash with the package. At 9 coming out of and a.m. an interview When asked if Reattached to the pill stated that it was, medication cart transpass is completed straight outside to where documents names on it should	D a.m., observation of a the downstairs unit was package was noted in the Resident #24's name visibly on 0:10 a.m., LPN #7 was observed other resident's room. At 9:10 was conducted with LPN #7. It is is is in the trash, LPN #7 when asked where the ash goes to after medication at LPN #7 stated, "It goes the main trash." When asked or anything with residents' d go, LPN #7 stated, "We will ings in the shredder." When					

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	PROVIDER OR SUPPLIER			91	REET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE '	(X5) COMPLETION DATE
F 164	Continued From p	•	F1	64			
	with residents' nar	to throw away pill packages ne still attached, LPN #7 stated, have been putting them."					
	staff member) #1, DON (Director of I corporate nurse w findings. ASM #3 packages should off the top of the p	5 p.m., ASM (administrative the administrator, ASM #2, the Nursing) and ASM #3, the vas made aware of the above stated that the names on the have been completely ablated backages. She stated that the the new pharmacy system into at 12:00 a.m.					
,	conducted with As facility was so foc medication carts or pharmacy system educate the nurse names off the pactitle nurses were ename by using a president sensitive the regular trash. system was differ	5 a.m. further interview was SM #3. ASM #3 stated that the used on making sure the were ready to try out the new that the facility did not think to es to make sure they ablated the ckages properly. She stated that educated on how to ablate the permanent marker to prevent information from getting into She stated that this new ent for the facility and they had ne system for less than 48			·		
<u>-</u> .		e provided regarding the above ner information was provided			·		-
	pain associated watchis information value, 11th edition	I to decrease mild to moderate with inflammatory disorders." was obtained from Davis's Drug n, p. 1087. ed to decrease blood pressure.					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION  ING		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 164	This information we Guide, 11th edition (11) Plavix-antiplat Used to prevent strobtained from Dav 11th edition, p. 325 (12) Lipitor- used to information was observed for Nurses, (13) Colace-Used This information we Guide for Nurses, (14) Ocuvite Luteir macular degeneral obtained from the https://nei.nih.gov/(15) Namenda-use associated with Alzinformation was observed Guide for Nurses, (16) Spironlactalor (pulls fluid off) and pressure. This info	as obtained from Davis's Drug, p. 151. elet used to thin the blood. roke. This information was is's Drug Guide for Nurses, i. decrease cholesterol. This etained from Davis's Drug 11th edition, p. 629. to soften the passage of stool. as obtained from Davis's Drug 11th edition, p. 442. n-Used to prevent age related tion. This information was National Institutes of Health.	F1	64			
F 272 SS=D	483.20(b)(1) COM ASSESSMENTS  The facility must ca comprehensive, reproducible assesfunctional capacity  A facility must make assessment of a resident assessment.	onduct initially and periodically accurate, standardized ssment of each resident's  The accomprehensive esident's needs, using the ent instrument (RAI) specified assessment must include at	F 2	272			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			910	REET ADDRESS, CITY, STATE, ZIP CODE 11 BON AIR CROSSINGS DRIVE 1N AIR, VA 23235			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE		(X5) COMPLETION DATE
F 272	Identification and of Customary routine Cognitive patterns; Communication; Vision; Mood and behavion Psychosocial well-Physical functioning Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentiate Documentation of the additional assess areas triggered by Data Set (MDS); as	lemographic information;  r patterns; being; g and structural problems; and health conditions; nal status;  s and procedures; al; summary information regarding essment performed on the care the completion of the Minimum	F2	272	The facility strives to document the date and location for triggered areas the CAA summary in the MDS. The location and da 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 or Resident #2's admission W assessment. The CAA sec was addressed by updating location and date information."  All residents have the potential to be affected.	ate  d s" of IDS tion g the		
	by: Based on staff intreview, and clinical determined that fat date and location (Care Area Assest the MDS (minimum)	ENT is not met as evidenced erview, facility document al record review it was icility staff failed to document for triggered areas on the CAA sment summary) in Section V of m data set) assessment for one the survey sample; Resident			Prior to signing and locking comprehensive assessment the MDS Coordinator will review each CAA to ensur completion.  Employees responsible for completing MDS sections be educated by the MDS Coordinator on completing parts of the MDS assessment.	ts e will g all		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPROPERTIES OF THE A	) BE	(X5) COMPLETION DATE
F 272	The facility staff fair and date of informathat was utilized to the triggered area of CAA in Section V, of MDS assessment reference date) of The findings included Resident #2 was an and readmitted on included but not liminsomnia, depressi (gastrointestinal) be Resident #2's mosset) was a quarterl (assessment reference dent was coded the ability to make out of 15 on the Bl Status) exam. Resident was coded the ability to make out of 15 on the Bl Status) exam. Resident was coded the ability to make out of 15 on the Bl Status) exam. Resident was fers and persistant with bathing, and review of the climinate comprehence the comprehence of CAA document contained in this contained in this contained in this contained in this contained in the CAA decided in Section of Informatical Review of the CAA decided in	led to document the location ation from the clinical record complete the assessment of of "Nutritional Status" on the of Resident #2's admission with an ARD (assessment 2/08/16.  e: dmitted to the facility on 2/8/16 6/28/16 with diagnoses that nited to spinal stenosis(1), ion, chronic kidney disease, Gleed and muscle weakness. It recent MDS (minimum data y assessment with an ARD ence date) of 5/12/16. The das being cognitively intact in daily life decisions scoring 14 MS (Brief Interview for Mental sident #2 was coded as a assistance from staff with onal hygiene; dependent on and independent with meals. sical record revealed the most sive MDS was the admission of 2/08/16. This review in V (Care Area Assessment a column, titled "Location and mentation." The data clumn for the triggered area: did not contain a date and tion.	F	272	Assessments will be randor 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	nly	
	area, "Nutritional S On 6/30/16 at 11:2 conducted with RN director of MDS. S	on of information for triggered status." 7 a.m., an interview was I (Registered Nurse) #3, the She stated that the nutritional #2 was overlooked. She stated					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
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F 272	in the clinical recort to support the trigg facility uses the RA Instrument) manual On 6/30/16 at appr (Administrative Standministrator, ASM Mursing) and ASM made aware of the information was presection V of the Magage the following 1. Check column A 2. For each trigger a new care plan, continuation of curaddress the problem assessment of the the Care Plan column addressed in the Care Plan column B if addressed in the Care Column B if addressed in the Care Column B if addressed in the Care Review of CMS's eshould include information column the CAA can be for should include information and this care area.  Review of CMS's estricted in the Care Review of CMS's estricted in the Care Area.	ion is the date and the location of where information was found pered CAA. She stated that the AI (Resident Assessment all when completing the MDS. roximately 1:00 p.m., ASM aff Member) #1, the AI #2, the DON (Director of #3, the corporate nurse where a above findings. No further resented prior to exit. DS documents at the top of the instructions:  Aif the Care Area is triggered.  The Care Area, indicate whether are plan revision, or rent care plan is necessary to em(s) identified in your acrea area. The Addressed in the must be completed within 7 to the RAI (MDS and CAA(s)). The triggered care area is					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
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F 272 F 281 SS=D	Documentation" or (Section V of the MCAA information a documentation ca record. Also indica Planning Decision area is addressed  (1) "Spinal stenosispine. The narrownerves and spinal This information with Institutes of Health https://www.nlm.nis.html.  483.20(k)(3)(i) SEPROFESSIONAL	ocation and Date of CAA column on the CAA Summary MDS 3.0) to note where the and decision making in be found in the resident's rate in the column "Care" whether the triggered care in the care plan." is causes narrowing in your raing puts pressure on your cord and can cause pain." was obtained from the National h. ih.gov/medlineplus/spinalstenos RVICES PROVIDED MEET STANDARDS		272			
	This REQUIREMI by: Based on staff in review, clinical red complaint investig the facility staff fa standards of prace the survey sample The facility staff fa	ailed to correctly transcribe a I medication for administration to					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY PLETED
	•		A. DUILL			(	
		495394	B. WING			06/	30/2016
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F 281		age 15 admitted to the facility on	F	281 <sup>-</sup>	F Tag 281:		
	8/25/214 with a readiagnoses that includementia, COPD (disease - causes of	admission on 2/25/15 with luded, but were not limited to; chronic obstructive pulmonary difficulty with breathing), high d atrial fibrillation (irregular			The facility strives to correctly transcribe physicial ordered medications. Resident #20 did not have correctly transcribed physician ordered medications.		
	set) was an annua (assessment refer Resident #20 was 15 on the Brief Inte	esident #20's most recent MDS (minimum data t) was an annual assessment with an ARD ssessment reference date) of 2/26/16. esident #20 was coded as a 12 out of a possible on the Brief Interview for Mental Status IMS), indicating that the resident was			for administration. There were no negative outcomes. Resident #20 was a hospice patient and expired.		
-	moderately cognition  A review of Resider revealed, in part, to the several se				All residents have the potential to be affected.  The DON or designee will educate all licensed nurses correct electronic order entrand following physician orders.  The administrative nurses we check orders during clinical	ry vill l	
	hour prn (as need Further review of I revealed, in part, to renewal forms ser "(Name of Reside 0.25 ml (5 mg) po signed by the nurs 3/14/16.	ed) for pain / sob."  Resident #20's clinical record in following prescription in to the pharmacy to be filled; int #20) Morphine 20 mg / ml in following prescription in the following pr			operations meeting for correntry 5 times per week for 4 weeks.  Variances be reviewed in the monthly quality assurance meeting with additional	4	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION  3	СОМ	E SURVEY PLETED
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F 281	(as needed) pain / and dated 3/15/16  A review of Reside of active orders da in part, the followir "Start 12/30/15 En of 2/29/16. Morphisoln (solution) 0.25 Telephone order fr physician) taken b 12/30/15 7:11 p.m  A review of Reside administration received the Resident #20 Morphine sulfate current with the administration received the medimidnight between February and Marone documented to be administration ordered to be	If you was a signed by the physician sob." signed by the physician order sheet ated 3/1/16 - 3/31/16 revealed, ag documentation; d 2/28/17. Active recertified as the Sulf (sulfate) 100 MG/5 ML oral every 3 hours pain. For ML oral every 3 hours pain. For (name of primary y (name of nurse) noted on by (name of nurse)."  In the #20's MARs (medication ords) dated January 2016, d March 2016 revealed, in part, was documented as receiving under the following order: 100 mg /5 ml soln. 0.25 ml for pain." Resident #20 cation one time each day at 1/1/2016 and 3/18/2018.  Resident #20's January, ch 2016, MARs revealed only ime (midnight) and one box administering and signing for of the Morphine Sulfate hinistered every three hours to ere were no other boxes and d on the MARs for administering ate every three hours as		281	monitoring and education provided as needed.  Completion date: July 29, 2016		
	conducted with AS member) #2, the	5 a.m. an interview was SM (administrative staff director of nursing. ASM #2 ew the Morphine Sulfate order					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	COM	PLETED
		495394	B. WING			06/3	30/2016
	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 281	#20 should have to 3/18/16. ASM # stated that Reside Sulfate every three whether or not Re Morphine Sulfate stated that he was "They (the nursing (the computer systimes to documen would not have flated on 6/30/16 at apprenting was held ASM #2, the directorporate nurse s	and to explain what Resident been administered from 1/1/16 #2 reviewed the orders and int #20 was to receive Morphine in hours. ASM #2 was asked sident #20 was administered every three hours, ASM #2 not. ASM #2 further stated, if staff) put the order in wrong, it item) did not give them enough to the total the did not give them enough to the given."  Troximately 12:30 p.m. a with ASM #1, the administrator, for of nursing and ASM #3, the pecialist. At this time the	F2	281			
F 282 SS=D	the concerns. No provided prior to	ih.gov/medlineplus/druginfo/me ERVICES BY QUALIFIED	F	282		-	
	by:	ation, staff interview, clinical					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	(X3) DATE SU COMPLE	
		495394	B. WING		06/30/	2016
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F 282	record review, and was determined the follow the plan of conthe survey sample. The facility staff fair on at all times, per The findings included Resident #12 was 6/8/16 with the diagnost he findings included Resident #12 was 6/8/16 with the diagnost he findings included Resident #12 was 6/8/16 with the diagnost he findings included Resident #12 was 6/8/16 with the diagnost he findings included Resident #12 was 6/8/16 with the diagnost he findings included Resident #12 was 6/8/16 on the diagnost he findings included Resident #12 was 6/8/16 on the diagnost findings included Resident #12 was	facility document review, it at the facility staff failed to are for one of 24 residents in Resident #12.  led to ensure a clip alarm was Resident #12's plan of care.  le:  admitted to the facility on gnoses of but not limited to e, coronary artery disease, ortness of breath, seizures, eurogenic bladder, and a er.  IDS (Minimum Data Set) was with an ARD (Assessment f6/15/16. The resident was cognitively impaired in ability to isions, scoring a 7 out of a BIMS (Brief Interview for am. The resident was coded as a for bathing; extensive sfers and hygiene; limited esing and ambulation; and ing. The resident was coded to of motion limitations of upper ies.  Inical record revealed a lated 6/8/16 for "Safety Alarm: ed/Chair. Check placement of shift."		Tag 282: The facility strives to the plan of care. Resi #12's care plan was no followed to ensure a salarm was on at all time. Resident #12's care placement was under resident #12's work chair cushion on 6/30 ensure compliance with safety device.  C.N.A. #2 received act training regarding complacement & checks of placement & function.  The DON or designees educate all licensed ston following the plan for safety devices to it proper function, the redocumentation for any noncompliance of the	dent ot clip nes. lan has  d.  placed wheel- /16 to th the  ditional rect of alarm ing.  will aff of care nclude equired y	
	made of Resident	#12. He was in his wheelchair his bed (window bed) and next			,	

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F 282	to him was a regularound in his wheel box hanging on the Next he was fidget it down in the regulation observed to go pivot, and sit on the because there was from the clip attack was laying in the removing the alarm to closer to the bed a attached to him an #12 was then observating phone call picked the alarm be put it in his jacket palarm less likely to CNA #2 (Certified resident's room, where Resident #12 looked at his room did not notice the amanner that would fall, and did not co	ar chair. He was turned blochair, removing the clip alarm eleft handle of the wheelchair, ing with the alarm and then laid lar chair next to him. He was let up out of the wheelchair, ele bed. The alarm did not go off too much slack in the cord land to him to where the alarm egular chair. By Resident #12 box, it ensured the alarm was lind would not pull at the clip land activate the alarm. Resident erved sitting on the bed and so After a few minutes, he locket, further making the late be activated. At 3:00 p.m., Nursing Assistant) entered the lent all the way into the room looked at Resident #12 and late and left the room. She alarm was not placed in any lactivate it if the resident had a rrect the situation to ensure the yorn in a manner that would	F 29	resident use of safety & the updating of the plan as needed.  Compliance will be nothrough random check resident safety devices times per week for 4 variances will be reviewed in the month quality assurance measuith additional monit and education provide needed.  Completion date: July 29, 2016	care  conitored ks of s for 5 weeks.  aly etting oring	
	observed up in his the door to the roo An observation of reveal where the o	30 a.m., Resident #12 was wheelchair in his room near om. His clip alarm was not on. the resident's bed area failed to lip alarm was at this time. in the room with the roommate.				
	made of Resident the therapy room.	9 p.m., an observation was #12 sitting in his wheelchair in He was at the table, not doing				

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING   COMPLETE	)/2016
00/30/2	7/2016
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF BON AIR  STREET ADDRESS, CITY, STATE, ZIP CODE  9101 BON AIR CROSSINGS DRIVE  BON AIR, VA 23235	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM-	(X5) COMPLETION DATE
On 6/30/16 at 3:55 p.m., an observation was made of Resident #12 in his wheelchair in the hallway. The cipi palarm 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 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-compilant 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	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
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		TENEVI OF DESIGNATES			ON AIR, VA 23235  PROVIDER'S PLAN OF CORRECTIO	NI I	are
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F 282	following the plan of stated there isn't or documented evider non-compliant with None was provided. According to Funda Williams and Wilki documented, "A work communication to members that help care The nursing information about and goals. It contains and is used to direct revise and update there are changes with new orders."  (1) According to J fem-pop (femoral pused to treat a bloom Information obtains http://www.hopkins_procedures/cardipass_surgery_92, 483.25 PROVIDE HIGHEST WELL is Each resident must provide the necessor maintain the highest with the service of the service of the service of the service of the plantage of the	of care was requested; OSM #3 ne. In addition, any nee of the resident being the alarm was requested. If by the end of the survey.  It is a su		309			
	accordance with the and plan of care.	ne comprehensive assessment					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	f ' '		CONSTRUCTION	СОМ	SURVEY PLETED
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F 309	by: Based on staff int review, clinical recomplaint investig the facility staff fail to maintain the hig of 24 residents in 20, 1 and 9  1. The facility staff sulfate (1) to Resident (1) to Resident (1) to Resident (2) and (2) and (3) and (4) and	erview, facility document ord review and in the course of ation, it was determined that led to provide care and services thest level of wellbeing for three the survey sample, Resident #s of failed to administer morphine dent #20 as ordered by the failed to follow the physician ister the full course of antibiotics two occasions, 3/26/16 and		309	F Tag 309:  1 & 2  Facility strives to follow physician orders and ass they are entered correctl Residents #20 & #1. Re #20 did not receive moras ordered. Resident #1 not receive the full cours antibiotics. There were negative outcomes for resident #20 or #1. Resi #20 was a hospice patier expired. Physician was notified that the antibiot course for Resident #1 v not fully administered. In new orders were received. All residents have the potential to be affected.	ure y. sident ohine did se of no dent nt and ic vas	
	sulfate (1) to Resiphysician.  Resident #20 was 8/25/214 with a rediagnoses that income.	de:  ff failed to administer morphine dent #20 as ordered by the sadmitted to the facility on eadmission on 2/25/15 with cluded, but were not limited to; (chronic obstructive pulmonary			The DON or designee we service licensed nurses of following physician order and electronic order entrensure orders are correct entered into the electronic health record.	on ers y to ly	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION  NG		E SURVEY IPLETED
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F 309	blood pressure are heart beat).  Resident #20's m set) was an annu (assessment refe Resident #20 was 15 on the Brief In (BIMS), indicating moderately cognital A review of Residerevealed, in part, 12/30/15, signed 1/5/16; "12/30/1 moderate to sever ml (milliliter) 0.25 as needed) sob (3/15/16; "D/C (dis 20 mg / ml give 0 (sublingual - ben prn (as needed)  Further review of revealed, in part, renewal forms se "(Name of Resid 0.25 ml (5 mg) p signed by the nu 3/14/16. "(Name of Resid 0.25 ml (5 mg) p (as needed) pair and dated 3/15/16 me set of the second sec	difficulty with breathing), high and atrial fibrillation (irregular ost recent MDS (minimum data al assessment with an ARD brence date) of 2/26/16. It is coded as a 12 out of a possible terview for Mental Status of that the resident was tively impaired.  Ident #20's clinical record the following telephone orders; and dated by the physician on 5 Morphine (used to treat ere pain (1)) 20 mg (milligrams) / ml Q3H prn (every three hours shortness of breath)." and dated by the physician on acontinue) morphine. Morphine 0.25 ml (5 mg) po (by mouth) / sleath the tongue) q1 (one) hour for pain / sob."  Resident #20's clinical record the following prescription ent to the pharmacy to be filled; ent #20) Morphine 20 mg / ml o q3 hrs (every three hours)." rese practitioner and dated ent #20) Morphine 20 mg / ml. o / sl q1 hr (every one hour) prn o / sob." signed by the physician 6.	F 30	Two nurses will verorder entry.  Administrative nurse audit electronic order clinical operations ratimes per week for 4. The results of the audity assurance manded education provinceded.  3)  The facility strives to communication and coordinated plan of the hospice provider resident. Resident flave a coordinated initiated timely. The care plan was received placed on the medical residents have the potential to be affect to DON or designee we each newly admitted medical record for the care plan.	res will rers in daily recting 5 4 weeks. redits will recting recting recting recting recting rection as recti	
	A review of Resid	dent #20's physician order sheet				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED C			
		495394	B. WING	i	<u>-</u>	4	/30/2016
	PROVIDER OR SUPPLIER  JRELS OF BON AIR		•	9.	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235		
(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 SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	of active orders da in part, the followin "Start 12/30/15 En of 2/29/16. Morphis soln (solution) 0.25 Telephone order fr physician) taken b 12/30/15 7:11 p.m.  A review of Reside administration rece February 2016 and that Resident #20 Morphine sulfate every 3 hours; ora received the medi midnight between  Further review of I February and Mar one documented to below this time for the administration ordered to be adm Resident #20. Th times documented the Morphine Sulf ordered by the phy  Further review of did not reveal any #20 had complain  On 6/30/16 at 9:25 conducted with As member) #2, the was asked to revi	ated 3/1/16 - 3/31/16 revealed, and documentation; d 2/28/17. Active recertified as the Sulf (sulfate) 100 MG/5 ML of ML oral every 3 hours pain. Tom (name of primary y (name of nurse) noted on by (name of nurse)."  The t		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 later than 72 hours after admission to hospice service.  The DON or designee will audit the process for compliance for 3 months. Variances will be reviewed the monthly quality assurar meeting with additional monitoring provided as indicated.  Completion date: July 29, 2016	ces.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	·	495394	B. WING			06/3	30/2016
	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	to 3/18/16. ASM # stated that Resider Sulfate every three whether or not Res Morphine Sulfate estated that he was "They (the nursing (the computer syst times to document would not have flaged on 6/30/16 at appropriate nurse spadministrative staff the concerns. No provided prior to the stated that the concerns is a concerns of the co	een administered from 1/1/16 2 reviewed the orders and at #20 was to receive Morphine hours. ASM #2 was asked sident #20 was administered every three hours, ASM #2 not. ASM #2 further stated, staff) put the order in wrong, it em) did not give them enough. It was entered incorrectly so it		309			
	ds/a682133.html  2. The facility staf orders and adminito Resident #1 on 4/9/16.	h.gov/medlineplus/druginfo/me  If failed to follow the physician ster the full course of antibiotics two occasions, 3/26/16 and					
	with diagnoses that to; depression, an	at included, but were not limited xiety, glaucoma (a disease of sease, high blood pressure and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER'CLIA IDENTIFICATION NUMBER:		1 ' '	DING	CON	COMPLETED	
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		. 1		ZIP CODE		
H DEFICIENCY M	JST BE PRECEDED BY FULL	l l	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
at #1's most resistant sessment refeat #1 was code to Brief Intervision indicating that tely cognitively of Resident at two physician ented the follow of a Z-Pak (Ancila infections, all infections and dated by Keflex (Also treat certain is pneumonia and (2)) 500 mg and dated by review of Resid, in part, MAI stration record that evidenced entation; instration Record (31/16. Azithroplet) once per tory infection. 3/26/16 11:59	cent MDS (minimum data change assessment with erence date) of 5/10/16. It das a 7 out of a possible ew for Mental Status the resident was a impaired.  If 1's clinical record revealed telephone orders that wing; antibiotic used to treat so called Azithromycin/cted. Zithromax 500 mg day (p.o.) (by mouth) the order respiratory infection)." The physician on 3/28/16. known as Cephalexin and fections caused by bacter of the physician on 4/4/16. It did not the respiratory tracting po BID (two times a day ITI (urinary tract infection) in the physician on 4/4/16. It did not the following order of the physician on 4/4/16. It did not the following order of the physician on 4/4/16. It did not the following order of the physician on 4/4/16 and Apthe following order of the physician of 4/4/16 and Apthe following.  The check off box to the check off box to the physician of the physician on 4/4/16 and Apthe following.  The check off box to the check off box to the physician of the physician of the physician of the physician of 4/4/16 and Apthe following.  The check off box to the physician of	an a		NCY)		
	ted From page of #1's most resonant reference in the sessment referenc	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL DUATORY OR LSC IDENTIFYING INFORMATION)  Ted From page 26  Int #1's most recent MDS (minimum datases a significant change assessment with sesessment reference date) of 5/10/16. Int #1 was coded as a 7 out of a possible me Brief Interview for Mental Status, indicating that the resident was ately cognitively impaired.  W of Resident #1's clinical record reveals two physician telephone orders that ented the following;  6 - Z-Pak (An antibiotic used to treat all infections, also called Azithromycin/max (1)) as directed. Zithromax 500 mg ams) x 1 (one) day (p.o.) (by mouth) the max 250 mg p.o. daily x 4 (four) days. Datases) URI (upper respiratory infection)."  and dated by the physician on 3/28/16.  - Keflex (Also known as Cephalexin and the tertage of the physician on 4/4/16. In review of Resident #1's clinical recorded, in part, MARs (medication stration records) for March 2016 and Aphate evidenced the following entation; instration Record for period: 3/1/16 thru 31/16. Azithromycin 500 MG Tablet one bet) once per day, oral for upper latory infection. Start: -3/26/16 03:30 p.m. 3/26/16 11:59 p.m." The check off box 13/26/16 11:59 p.m."	RESUMMARY STATEMENT OF DEFICIENCIES CHOPFICIENCY MUST BE PRECEDED BY FULL DUATORY OR LSC IDENTIFYING INFORMATION)  THE FORM page 26  Int #1's most recent MDS (minimum data is a significant change assessment with an issessment reference date) of 5/10/16. Int #1 was coded as a 7 out of a possible in the Brief Interview for Mental Status, indicating that the resident was ately cognitively impaired.  W of Resident #1's clinical record revealed, two physician telephone orders that ented the following; 6 - Z-Pak (An antibiotic used to treat all infections, also called Azithromycin/lax (1)) as directed. Zithromax 500 mg ams) x 1 (one) day (p.o.) (by mouth) then hax 250 mg p.o. daily x 4 (four) days. Dx possis) URI (upper respiratory infection)."  and dated by the physician on 3/28/16.  - Keflex (Also known as Cephalexin and is pneumonia and other respiratory tract infections) and other respiratory tract infections. Supply the physician on 4/4/16.  The review of Resident #1's clinical record and dated by the physician on 4/4/16.  The review of Resident #1's clinical record and the record of the physician on 4/4/16.  The review of Resident #1's clinical record and April that evidenced the following entation; instration records) for March 2016 and April that evidenced the following entation; instration Record for period: 3/1/16 thru 131/16. Azithromycin 500 MG Tablet one belet) once per day, oral for upper latory infection. Start: -3/26/16 03:30 p.m. 3/26/16 11:59 p.m." The check off box for	A95394  B. WING  STREET ADDRESS, CITY, STATE, 9101 BON AIR CROSSINGS DI BON AIR, VA 23235  SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL DILATORY OR LSC IDENTIFYING INFORMATION)  THE HISTORY OR LSC IDENTIFYING INFORMATION)  FREFIX  FROVIDER'S PLAN OR (EACH CORRECTIVE TAGE)  THE HISTORY OR LSC IDENTIFYING INFORMATION)  FREFIX  TAGE  PROVIDER'S PLAN OR (EACH CORRECTIVE TAGE)  FROVIDER'S PLAN OR CROSS-REFERENCED TO THE TAGE  THE HISTORY OR LSC IDENTIFYING INFORMATION)  FREFIX  TAGE  PROVIDER'S PLAN OR (EACH CORRECTIVE TAGE)  TAGE  FROVIDER'S PLAN OR (EACH CORRECTIVE TAGE)  FREFIX  TAGE  PROVIDER'S PLAN OR (EACH CORRECTIVE TAGE)  FREFIX  TAGE  PREFIX  TAGE  PROVIDER'S PLAN OR (EACH CORRECTIVE TAGE)  (EACH CORRECTIVE TAGE)  FREFIX  TAGE  PREFIX  TAGE  PROVIDER'S PLAN OR (EACH CORRECTIVE TAGE)  (EACH CORRECTIVE TAGE)  FREFIX  TAGE  PROVIDER'S PLAN OR (EACH CORRECTIVE TAGE)  (EACH CORRECTIVE TAGE)  FREFIX  TAGE  PREFIX  TAGE  PROVIDER'S PLAN OR (EACH CORRECTIVE TAGE)  (EACH CORRECTIVE TAGE  (FROVIDER'S PLAN OR (EACH CORRECTIVE TAGE)  (EACH CORRECTIVE TAGE  (FROVIDER'S PLAN OR (EACH CORRECTIVE TAGE)  (EACH CORRECTIVE TAGE  (FROVIDER'S PLAN OR (EACH CORRECTIVE TAGE)  FREFIX  TAGE  PROVIDER'S PLAN OR (EACH CORRECTIVE TAGE  (EACH CORRECTIVE TAGE  (FROVIDER'S PLAN OR (EACH CORRECTIVE TAGE  (EACH CORRECTIVE TAGE  (FROVIDER'S PLAN OR (EACH CORN TAGE  (FROVIDER'S PLAN OR (CROSS-REFERINCED TAGE  (EACH CORRECTIVE TAGE  (EACH CORRCTIVE TAGE  (FROVIDER'S PLAN OR (CROSS-REFERINCED  (EACH CORRCTIVE TAGE  (EACH CORRCTIVE TAG	A95394  DR SUPPLIER  F BON AIR  STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 22325  SUMMARY STATEMENT OF DEFICIENCIES 3TH DEFICIENCY MUST BE PRECEDED BY FULL DIATORY OR LSC IDENTIFYING INFORMATION)  FRICH TAG  FROM THE PROPURER PLAN OF CORRECTION PRECEDED TO THE APPROPRIATE  DEFICIENCY)  F 309  F	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		( СОМ	(X3) DATE SURVEY COMPLETED		
		495394	B. WING				C 30/2016
	PROVIDER OR SUPPLIER		:	910	EET ADDRESS, CITY, STATE, ZIP CODE  1 BON AIR CROSSINGS DRIVE  N AIR, VA 23235		
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	Extended Direction nurses initialed the instructed; 4/3/16; and 4/8/16. Day 7 given. On 6/30/16 at 8:40 conducted with LP LPN #2 was asked administering an a receive an order, esystem for whatevit should end. We ordered by the phywas important to was prescribed for medication is not given as or fully treated." On 6/30/16 at 11:2 conducted with AS member) #2, the ordered with AS member) #2, the ordered and April, and stated, "The agiven as ordered. Azithromycin should see that it was not not given as ordered. Azithromycin should see that it was not not given as ordered. Azithromycin should see that it was not not given as ordered. Azithromycin should see that it was not not given as ordered. Azithromycin should see that it was not not given as ordered. Azithromycin should see that it was not not given as ordered. Azithromycin should see that it was not not given as ordered. Azithromycin should see that it was not not given as ordered. Azithromycin should see that it was not not given as ordered. Azithromycin should not given as ordered.	age 27 Ins for 7 (seven) days." The following dates as given as 4/4/16; 4/5/16; 4/6/16; 4/7/16/, 4/9/16, was not initialed as a.m. an interview was N (licensed practical nurse) #2. It to describe the process for intibiotic. LPN #2 stated, "We enter it into the computer er date it should start and when administer the medication as visician." LPN #2 was asked if it complete all days the antibiotic r. LPN #2 stated, "When the given as ordered you should call the guest (resident) does not get dered the infection may not be all days the antibiotic of nurses. ASM #2 was and asked if Resident #1 had a of the antibiotics ordered in ASM #2 reviewed both MARs antibiotic ordered should be antibiotic ordered should		309			

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED C			
		495394	B. WING		06/30/2016	
	PROVIDER OR SUPPLIE		9	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	, , , , , , , , , , , , , , , , , , , ,	
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F 309	ds/a697037.html  (2)This information website: https://www.nlm.rds/a682733.html  3. The facility star communication at between the facility star communication at between the facility esident #9's cliric days after the initial Resident #9's cliric days after the initial Resident #9 was with diagnoses that to anemia, high the disorder, anxiety Resident #9's moset) was a signifiant ARD (assessment Resident #9 was in the ability to mout of 15 on the Status) exam. Requiring extensit transfers, dressin hygiene; and total meals.	in was obtained from the nih.gov/medlineplus/druginfo/me fif failed to ensure a coordinated plan of care ity and hospice provider for the hospice care plan and other nation were not available on nical record as of 6/29/16 (seven iation of hospice services).  admitted to the facility on 3/4/16 nat included but were not limited allood pressure, diabetes, thyroid depression, and failure to thrive the strecent MDS (minimum data cant change assessment with an ant reference date) of 3/4/16. Coded as being cognitively intact ake daily decisions scoring 12 BIMS (Brief Interview for Mental esident #9 was coded as we assistance from staff with an all dependence on staff with		,		
	the following ord (patient) to (Nam of (Name of physician) as HN	ent #9's clinical record revealed er initiated on 6/22/16, "Admit pt re of Hospice) under the services sician) and (Name of other MD (Hospice Medical Doctor) R (Do not resuscitate)				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, COM	(X3) DATE SURVEY COMPLETED	
		495394	B. WING	<b>.</b>		ı	C 30/2016
	PROVIDER OR SUPPLIER	3			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u> </u>	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	Morphine Sulfate (milliliters) 0.25 m under tongue) q (needed) Ativan (2) 1 mg 1 give po/sl q-8 hrs signed by the phy No hospice notes visit with Residen hospice care plar record for Reside approximately 2:1 was requested fromember) #3, the "The company pr Hospice was initianot in the building going to give ther On 6/30/16 at apphospice care plar top of the page d "06/29/16 at 4:39 On 6/30/16 at apphospice notes were requestaff member) #2 stated, "I will get On 6/30/16 at apphospice notes were roles were requestaff member) #2 stated, "I will get On 6/30/16 at apphospice notes were roles and roles and roles and roles and roles are roles are roles and roles are roles and roles are roles are roles and roles are roles and roles are roles are roles and roles are roles are roles are roles and roles are roles a	x-rays Pressure) Mattress (1) 20 mg (milligrams)/ml I po (by mouth)/ SL (sublingual: every) 4 hours for pain prn (as tab (tablet) dissolve in water prn anxiety." This order was sician on 6/23/16.  could be found regarding this t #9 on the clinical record. The was also not on the clinical nt #9. On 6/29/16 at 5 p.m. the hospice care plan om ASM (administrative staff corporate nurse. She stated, obably has not sent it over yet. ated on 6/22/16 so it is probably y yet. Medical Records are m a call."  proximately 7:00 a.m., the n was provided. A fax date at the ocumented the following: p.m."  proximately 1 p.m., all hospice ested from ASM (administrative t, the Director of Nursing. She	F	30			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILE		COMPLETED			
		495394	B. WING	i			C 30/2016	
	PROVIDER OR SUPPLIER			91	REET ADDRESS, CITY, STATE, ZIP CODE D1 BON AIR CROSSINGS DRIVE DN AIR, VA 23235	TATE, ZIP CODE		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 309	Continued From pa	age 30	F	309				
	initial hospice eval 6/22/16 (when the hospice nurse had had visited on 6/24 visited on 6/28/16. not placed on the the hospice notes	pice notes revealed that the uation was completed on care plan was developed), a visited on 6/23/16, social work 6/16 and a hospice aide had The hospice care plan was clinical record until 6/29/16 and were not placed on the clinical 6 when hospice faxed the notes						
	facility on 6/22/16 care area "Term IL	nt #9's care plan created by the and updated on 6/27/16 under L (Terminally III) documented in "Refer to hospice plan of	-					
	conducted with Rithospice nurse. We communication to visits a resident, so a resident and take Once hospice gets will print the document to place on the resident's clinical but I'm also new a Usually 5-6 days we when asked how know what is going no notes on the clinical of the computation of the computation of the computation of the communication to the communication to the communication of the communication of the communication to the communicat	26 a.m., an interview was N (Registered Nurse) #1, the then asked the process of the other nurses when hospice he stated that hospice will visit e notes on their own computer. It is to their office, hospice staff mentation and bring it with them sident's clinical record during en asked if seven days is a sare plan to be placed on the record she stated, "I think so, and learning the process. We bring the care plan back." facility staff is supposed to g with the resident if there are inical record from hospice she e gives a verbal report to the duty.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUI A. BUILE		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIE	R	1		,0/20 TO		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	On 6/30/16 at 4:1 conducted with LI #8. She stated the report to the facility resident. When a from hospice shorecord for continuously would say yes."  On 6/30/16 at appinterview was constaff member) #2 is supposed to know the company, ASM # verbal report from facility determine resident receiving plan from the host the clinical record will give a verbal facility will develop stated that sever	page 31  1 p.m., an interview was PN (Licensed Practical Nurse) hat hospice will give a verbal ity nurses when they visit a asked if notes or a care plan ould be placed on the clinical uity of care, LPN #8 stated, "I proximately 1:00 p.m., an anducted with ASM (administrative). When asked how facility staff now what is going on with any hospice services if notes are a clinical record from the hospice in the property of the care spice company is not placed on the property of the facility and then the property of the property of the plan of care for a graph of the property of the facility and then the property was a reasonable time for each days was a reasonable time for		309			
	hospice company part, the following FACILITY with a specifying the Rewill furnish. HOS patient's record to the metEach party such communication records to ensur Patient are met	spice contract from (name of y) for Resident #9 documents in g: "HOSPICE shall provide copy of the Hospice plan of care esidential Services that FACILITY SPICE shall document in the that this requirement has been is responsible for documenting ations in its respective clinical e that the needs of the HospiceHospice shall promote open and nication with FACILITY and shall					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235			
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F 323 SS=D	ensure that the prounder this agreemed Hospice plan of carplanning and care of No further information (1) Morphine Sulfarminimize severe particles and the edition, p. 843 (2) Ativan-depressed to decrease anxiety information was obtained for Nurses, 483.25(h) FREE OHAZARDS/SUPERTHE facility must energy and is possible; and	with sufficient information to vision of Residential Services ent is in accordance with the re, assessments, treatment coordination."  ion was provided prior to exit.  te- opioid analgesic used to ain. This information was is's Drug Guide for Nurses, is.  es the central nervous system y or used as a sedative. This intained from Davis's Drug  11th edition, p. 763.  F ACCIDENT	F3	323			
	by: Based on observative record review, and was determined the provide an environ hazards for 1 of 24 sample; Resident	inton, staff interview, clinical facility document review, it at the facility staff failed to ment free of accidents and residents in the survey #12.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA: IDENTIFICATION NUMBER:		(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED		
		495394	B. WING			1	C 30/2016
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F 323	a clip alarm was or of falls.  The findings included Resident #12 was 6/8/16 with the diaghigh blood pressur atrial fibrillation, she bladder spasms, in suprapubic catheter.  The most recent M an admission MDS Reference Date) or coded as severely make daily life decorated possible 15 on the Mental Status) example requiring total care assistance for transassistance for dressupervision for eat as having no rangular and lower extremited A review of the clir physician's order of Sensor Alarm to B and function every On 6/28/16 at 2:52 made of Resident in his room next to to him was a regular as a regular made of the clir physician's order of the clir physician's	at all times for the prevention  at all times for the prevention  active to the facility on gnoses of but not limited to e, coronary artery disease, ortness of breath, seizures, eurogenic bladder, and a er.  IDS (Minimum Data Set) was with an ARD (Assessment f6/15/16. The resident was cognitively impaired in ability to isions, scoring a 7 out of a BIMS (Brief Interview for am. The resident was coded as for bathing; extensive sfers and hygiene; limited ssing and ambulation; and ing. The resident was coded a of motion limitations of upper ites.  Inical record revealed a lated 6/8/16 for "Safety Alarm: ed/Chair. Check placement		323	F Tag 323:  The facility strives to proan environment free of accidents and hazards. Resident #12 did not have clip alarm on at all times prevention of falls. A sealarm replaced the clip at for Resident #12.  All residents have the potential to be affected.  Licensed nurses will veriplacement of clip alarms sign the electronic health record for documented compliance.  Staff members will be educated on the facility fawareness program to in placement of clip alarms	e a for nsor larm  ffy and clude	
	Next he was fidge	e left handle of the wheelchair. ting with the alarm and then laid lar chair pext to him. He was	1				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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F 323	then observed to g pivot, and sit on the because there was from the clip attach was laying in the re moving the alarm to closer to the bed a attached to him an #12 was then obse making phone call picked the alarm b put it in his jacket p alarm less likely to CNA #2 (Certified resident's room, w near Resident #12 looked at his room did not notice the a manner that would fall, and did not co alarm was being w make it functional.  On 6/30/16 at 10:3 observed up in his the door to the roo An observation of reveal where the co Therapy staff was  On 6/30/16 at 3:35 made of Resident the therapy room. any activities. His  On 6/30/16 at 3:55 made of Resident hallway. The clip	et up out of the wheelchair, et bed. The alarm did not go off it too much slack in the cord hed to him to where the alarm egular chair. By Resident #12 box, it ensured the alarm was not would not pull at the clip did activate the alarm. Resident erved sitting on the bed and is. After a few minutes, he ox up off the regular chair, and bocket, further making the be activated. At 3:00 p.m., Nursing Assistant) entered the ent all the way into the room, looked at Resident #12 and mate, and left the room. She alarm was not placed in any activate it if the resident had a rrect the situation to ensure the yorn in a manner that would		according to guest A list of residents will be provided for members to ensur compliance.  The DON or designed conduct random a residents with clip verify compliance week for 4 weeks.  Variances identify reviewed in the modulity assurance with additional modulity and education proposed.  Completion date: July 29, 2016	gnee will address to gnee will addits of p alarms to e, 3 times per s. lied will be nonthly meeting nonitoring ovided as		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 323	that was in the hal #5 was asked abo of the observation resident 20 minute OSM #5 was asked when the clip alarm OSM #5 stated ship present when the (LPN #7 - Licensed On 6/30/16 at 3:50 conducted with LF resident is suppose	ember), the physical therapist, Iway near Resident #12. OSM ut the clip alarm and informed of the alarm not in place on the es earlier, in the therapy room. It is she knew anything about m was put on Resident #12. It is edid know because she was nurse came and put it on him d Practical Nurse).  By p.m., an interview was PN #7. She stated that the sed to have it on at all times but	F	323			
	At risk for fall rela gait, impaired mothistory of falls, Dx CVA (stroke), limit sided weaked [sid March 2016, and plan was initiated intervention of "Be This intervention of Further review of notes, failed to re resident being no A review of the fa Program" did not of falls (i.e., interview) at risk.  On 6/30/16 at 4:3	re plan revealed one for "Falls: led injury related to: Unsteady bility, psychotropic drug use, (diagnoses) h/o (history of) led mobility, h/o seizures, right led mobility, right fem-pop (1) surgical other comorbidities." This care on 6/10/16 and included the led/chair alarm on at all times." was also initiated on 6/10/16, the care plan, as well as nurses weal any concerns with the n-compliant with the alarm.  Icility policy, "Falls Awareness readily address the prevention rentions and methods, etc.) of and identifying those who are					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER		1	91	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235		372010	
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F 323	[Administrative Sta	age 36 aff Member] #1, #2, and #3) of the findings. No further rovided by the end of the	F	323				
	Patricia A. Potter a Inc; Page 5. "Clie care. You need to and emotional inju and eliminating sa many factors, suc techniques, client medications, impa Learn your agenc reducing client fal multidimensional	of Nursing" 7th edition, 2009; and Anne Griffin Perry, Mosby, and safety is a priority in health o protect clients from physical cury by continually assessing for afety hazards. Clients fall due to h as improper transfer age, side effects of aired mobility, or confusion. y's fall prevention program for its. Programs that use a approach in designing fall gies have the greatest reduction						
	Springhouse Corp through 328- Fall Falls are a major among elderly pe- used to prevent fa or chairthe alarr	ndbook of Nursing Procedures poration 2006 pages 323 Prevention and Management: cause of injury and death oplean alarm system can be allsthe system adapts to a bed in sounds when the patient or transfer themselves						
-	fem-pop (femoral used to treat a blo Information obtain http://www.hopkir	nsmedicine.org/healthlibrary/test liovascular/femoral_popliteal_by						

AND PLAN OF CORRECTION  (X1) PROVIDERSOPPLIEROLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495394	B. WING			06/3	; 60/2016
	PROVIDER OR SUPPLIEF	, [		STF 910	REET ADDRESS, CITY, STATE, ZIP CODE 01 BON AIR CROSSINGS DRIVE DN AIR, VA 23235	1 00.0	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333 SS=D	1	SIDENTS FREE OF ED ERRORS	F;	333	F Tag 333:		
	The facility must eany significant me	ensure that residents are free of edication errors.			The facility strives to ensur medication administration passes are free from errors.	e	
	by: Based on observ document review was determined the medication admin significant medica	ation, staff interview, facility and clinical record review, it hat facility staff failed to ensure listration pass was free from ation errors for one of five ledication administration dent #1.			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 Cru List".	2 sh	
	20 MEQ (potassic release during me	ushed the medication Klon Clor  Im supplement (1)) extended edication administration ailed to safely administer the		The second secon	All residents have the potential to be affected.		
	The findings inclu		,		The DON or designee will educate all licensed nurses the "Do Not Crush List"		•
	with diagnoses the to atrial fibrillation osteoporosis, Nordisorder and depide Resident #1's moset) was a signific (assessment reference Resident #1 was cognitively impair decisions scoring Interview for Menwas coded as recognitively as second to a second resident #1 was coded as recognitively impair decisions scoring interview for Menwas coded as recognitively impair decisions scoring interview for Menwas coded as recognitively impair decisions scoring interview for Menwas coded as recognitively impair decisions scoring interview for Menwas coded as recognitive intervi	admitted to the facility on 1/2/15 at included but were not limited at high blood pressure, arthritis, n-Alzheimer's Dementia, anxiety ression.  Set recent MDS (minimum data cant change MDS with an ARD erence date) of 5/10/16. Coded as being severely red in the ability to make daily life at 7 out of 15 on the BIMS (Brief stal Status) exam. Resident #1 quiring extensive assistance ansfers, dressing, eating, toileting			located on the medication for reference. The 5 rights medication administration be reviewed to include physician notification for residents unable to tolerate	of will	

AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIER CLIA IDENTIFICATION NUMBER:		A. BUILE		COMPLETED			
,		495394	B. WING	i		i .	C 30/2016
	PROVIDER OR SUPPLIER		<u> </u>	9 <sup>,</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235	1 00/	30/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE.	(X5) COMPLETION DATE
F 333	and personal hygi staff with bathing.  On 6/29/16 at 7:50 administration obs 7:55 a.m., LPN (L prepared the follow #1:  Tramadol (2) 3 has Restasis (3) 0.05 eyes  Flecaintide aceta Lasix (5) 20 mg Losartan Potassi prednisone (7) 2.0 Zoloft HCL (hydrow Klon Chlor (1) 20  At 8:09 p.m., LPN together including applesauce to the over to Resident in behind the medication to the Conformal of the "DO NOT CR medication cart and "Common Oral DourshedPotassi release." LPN #2 orders that it may orders. I can go Review of Resided	ene, and total dependence on 5 a.m., medication servation was conducted. At icensed practical nurse) # 2 wing medications for Resident of tablets to =75 mg (milligrams) percent - 1 gtt (drop) to both te (4) 50 mg-1 tablet 1 tablet (mm (6) 25 mg-1 table		333	prescribed method ordered obtain a change.  The DON or designee will conduct random medicatio pass observations weekly for 4 weeks to ensure compliant.  Variances identified will be reviewed in the monthly quality assurance meeting with additional monitoring and education provided as needed.  Completion date: July 29, 2016	n for nce.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING			061	30/2016
	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	50/2016
THE LAU	RELS OF BON AIR	•			ON AIR, VA 23235		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		BE	(X5) COMPLETION DATE
F 333	Continued From pa	-	F:	333			
•	crush her potassium supplement.  Review of Resident #1's potassium levels dated 5/9/16 revealed that her potassium level was within normal range.						
	conducted with LPI administer potassic cannot swallow me "Call the doctor to gin liquid form or and that potassium was be crushed. When	0 a.m., an interview was N #8. When asked how to um chloride to a resident who dications whole she stated, get an order for the potassium other form." LPN #8 stated is extended release and cannot a asked if the doctor has ever rush a potassium tablet she am aware of."	-				
	conducted with LPI cannot crush potas pharmacy to get po	5 a.m., an interview was N #1. LPN #1 stated, "You ssium. You would have to call otassium in a different form." Ishing potassium interferes					
		I #2, the DON (Director of I #3, the corporate nurse was		,		~	
		, "Medication Administration" e administration of potassium.					
	No further information	tion was presented prior to exit.		-			
	the prevention of p Potassium chloride	MEQ-used as a supplement for notassium deficiency. "NOTE: extended-release tablets are hole without crushing, chewing					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495394	B. WING			30/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<del></del>	50/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		HOULD BE	(X5) COMPLETION DATE	
F 333	or sucking the table obtained from Davi 11th edition, p. 997 (2) Tramadol- analysevere pain. This is Davis's Drug Guide 1197.  (3) Restasis- Used those with dry eye obtained from the interpretation of the interpretation	ets." This information was s's Drug Guide for Nurses, gesic used to treat moderate to information was obtained from e for Nurses, 11th edition, p.  to increase tear production in disease. This information was National Institutes of Health. In gov/medlineplus/druginfo/me etate- used to prevent certain ening irregular heartbeat. This obtained from The National in the new Mediane for the new Mediane f	F3	333			

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 07/12/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION I		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
	į	495394	B. WING		C		
	PROVIDER OR SUPPLIER	400004	9	TREET ADDRESS, CITY, STATE, ZIP CODE 1101 BON AIR CROSSINGS DRIVE 3ON AIR, VA 23235	_ 06/30	0/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 333 F 514 SS=D	used to treat gener information was ob Guide for Nurses, 1 483.75(I)(1) RES	ge 41 mg-antidepressant that is also alized anxiety disorder. This tained from Davis's Drug 1th edition, p. 1103.  LETE/ACCURATE/ACCESSIB	F 333				
	resident in accorda standards and prac accurately docume systematically orga The clinical record	aintain clinical records on each nce with accepted professional stices that are complete; nted; readily accessible; and nized.  must contain sufficient if the resident; a record of the					
	resident's assessm services provided;	ents; the plan of care and the results of any ening conducted by the State;			-		
	by: Based on staff into and facility docume that facility staff fail accurate clinical re	NT is not met as evidenced erview, clinical record review, ent review, it was determined led to maintain a complete and cord for three of 25 residents le; Resident #6, #9, and #4.					
	MAR (Medication A months of April and	failed to ensure a complete administration Record) for the June 2016 for Resident #6.					
		failed to ensure the hospice n were placed on the clinical t #9.					

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495394	B. WING		C 06/30/2016		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL.  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION	ИО	
F 514	#4's clinical record resident's documer  The findings includ  1. Resident #6 wa 3/28/16 with diagnoral limited to high bloostroke, one sided prin walking and must resident #6's mosset) was a 60 day ARD (Assessment Resident #6 was coimpaired in cognitive assessment for me was coded as required in staff with transpersonal hygiene; with bathing.  Review of Resident MAR (Medication Arevealed no electromedications:  "Baclofen (2) 10 Mat 2:00 p.m., 4/12/10:00 p.m., 4/18/16 p.m. and 6/18/16 are Enteral Water Flust (milliliter) flushes, 64/7/16 at 2:00 p.m.	failed to ensure that Resident did not include another natation.  e:  s admitted to the facility on oses that included but were not d pressure, thyroid disorder, aralysis, aphasia (1), difficulty ocle weakness.  It recent MDS (Minimum Data scheduled assessment with an Reference Date) of 5/26/16. The odd as being moderately of status on the staff ontal status exam. Resident #6 iring extensive assistance of sers, dressing, toileting, and and total dependence on staff of the third and the total dependence on staff of the third and the total dependence on the following of (milligram) tablet on 4/7/16 at 3 at 2:00 p.m., 4/17/16 at 10:00 p.m., 4/17/16 at 10:00 p.m., 4/12/16 at 10:00 p.m., m., 4/18/16 at 10:00 p.m., m., 4/18/16 at 2:00 p.m. and	F 514	I) The facility strives to ensure 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 report.  The missed medication reports will be reviewed in the clinical operations meeting stimes per week for 4 weeks werify accuracy.	te en he		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED		
		495394	B, WING		C	
NAME OF I	DOWNER OF CURRIER	493394		STREET ADDRESS, CITY, STATE, ZIP CODE	06/30/2016	
NAME OF I	PROVIDER OR SUPPLIER					
THE LAU	JRELS OF BON AIR			9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION	
F 514	Review of the April revealed no docum signatures on the at On 6/30/16 at 10:2 conducted with LPI #5, regarding what LPN #5 stated that given or just not signatured that often at check for holes in nursing is expected the MAR. She stain not given then a not documenting the reno documentation	and June 2016 nursing notes tentation related to the missing	F 514	quality assurance meeting with additional monitoring provided as needed.  2) The facility strives to ensure that hospice notes and a carplan are placed on the clinic record for hospice residents Resident #9 did not have the hospice notes or care plan of the record. No negative outcome resulted. The hospice care plan was immediately placed on the	e e cal	
	conducted with LP blanks meant on the nurse probably for medication was give administration will holes or blanks on the nurse responsion the April 2016 MARThis nurse could not not 100 follows of the April 2016 may administrative states (Director of Nursin nurse were made a Facility policy titled Analysis" documents.	6 a.m., an interview was N #7. When asked what he MAR, LPN #7 stated that the got to sign off that the yen. She also stated that do frequent audits to monitor the MAR. LPN #7 stated that able for most of the blanks on R was on vacation at that time. ot be reached for an interview. Toximately 1:00 p.m., ASM ff member #2, the DON g), and ASM #3, the corporate aware of the above findings.  I, "Medical Records Chart hat in part, the following: "In he clinical record in its most		All residents have the potential to be affected.  All hospice providers who provide services to the facili 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 months for compliance.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED C				
		495394	B. WING			06/30/2016		
	PROVIDER OR SUPPLIER  JRELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235				
(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 SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 514	accuracy, and regularized record shown basis. Each record appropriate information complete, and time signed by the appropriate information in the signed and information in	ulatory compliance, each uld be reviewed on a regular d should contain required and ation to verify accurate, ely entries, which are dated and copriate staff."  ation is found in Potter and stals of Nursing 6th edition occumentation is anything that is relied on as record or ad persons. Documentation dical record is a vital aspect of Nursing documentation must be nensive, and flexible enough to ta, maintain continuity of care, nes, and reflect current and practice.		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 record for compliance of a complete medical record.	ds		
	parts of the brain make it hard for you mean to say." from The Nationa https://www.nlm.nl.  (2) Baclofen-skele decrease muscle obtained from Da 11th edition, p. 21  (3) Enteral Water used to feed patie adequate oral inta	order caused by damage to the that control language. It can ou to read, write, and say what 'This information was obtained I Institutes of Health. ih.gov/medlineplus/aphasia.htmetal muscle relaxant used to spasticity. This information was vis's Drug Guide for Nurses, 3.  Flushes- "Enteral feeding is ents who cannot attain an ake from food and/or oral ments, or who cannot eat/drink			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 we conduct an audit weekly for weeks for compliance and randomly thereafter.	ill		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/30/2016	
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/3	30/2010
	RELS OF BON AIR			91	101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235		
(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 APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 514	safely. The aim is and so improve or tube is placed into usually by the nose skinFlushes prevalue of the nose ship of the nose of the n	to improve nutritional intake maintain nutritional statusA the stomach or intestines e, mouth or directly through the vent clogging of the feeding" as obtained from the National nunih.gov/books/NBK49253/.  failed to ensure the hospice on were placed on the clinical of the facility on 3/4/16 at included but were not limited be pressure, diabetes, thyroid depression, and failure to thrive. It recent MDS (minimum data and change assessment with an areference date) of 3/4/16. Soded as being cognitively intact ke daily decisions scoring 12 the limited sident #9 was coded as assistance from staff with g, eating, toileting, and personal dependence on staff with the of Hospice) under the services cian) and (Name of other D (Hospice Medical Doctor). (Do not resuscitate)		514	Variances identified will be reviewed in the monthly quality assurance meeting with additional monitoring provided as needed.  Completion date: July 29, 2016		
	Code Status DNR Activity Level: as t Diet: as tolerated						

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DIAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COM	E SURVEY IPLETED	
		495394	B. WING		1	C /30/2016
	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) IC PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE
F 51	Cancel any lab or APP (Alternating If Morphine Sulfate (milliliters) 0.25 m under tongue) q (eneeded) Ativan (2)1 mg 1 give po/sl (by moueight hours) properties with Resident hospice care plan record for Residerapproximately 2:1 was requested from member) #3, the "The Company properties was initian not in the building going to give them On 6/30/16 at apphospice care plan top of the page do "06/29/16 at 4:39 On 6/30/16 at apphospice was requested from the page do "06/30/16 at apphospice care plan top of the page do "06/30/16 at apphospice notes were requestaff member) #2 stated, "I will get to "06/30/16 at apphospice notes were reducted to the page do "06/30/16 at apphospice notes were requestaff member) #2 stated, "I will get to "06/30/16 at 08:1	ex-rays Pressure) Mattress (1) 20 mg (milligrams)/ml I po (by mouth)/ SL (sublingual: every) 4 hours for pain prn (as tab (tablet) dissolve in water of th/sublingual) q-8 hrs (every exith/sublingual) q-8 hrs (every exith/sublingual	F	514		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SUPP		1, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495394	B. WING	;		06/3	; 60/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235			7072010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	initial hospice eval 6/22/16 (when the hospice nurse had visited on 6/28/16. not placed on the the hospice notes record until 6/30/1 over to the facility.  On 6/30/16 at 10:: conducted with RI hospice nurse. We communication to visits a resident, sa resident and take Once hospice get will print the document of the next visit. When given for the certain to the certain the certain to the certain the c	pice notes revealed that the luation was completed on care plan was developed), a livisited on 6/23/16, social work 4/16 and a hospice aide had. The hospice care plan was clinical record until 6/29/16 and were not placed on the clinical 6 when hospice faxed the notes of the other nurses when hospice he stated that hospice will visit the notes on their own computer. It is to their office, hospice staff mentation and bring it with them sident's clinical record during the notes on the record during the process. We bring the care plan back. If facility staff is supposed to g with the resident if there are inical record from hospice she e gives a verbal report to the		514			
	conducted with Lf #8. She stated th facility nurses who asked if notes or be placed on the	1 p.m.; an interview was PN (Licensed Practical Nurse) at will give a verbal report to the en they visit a resident. When a care plan from hospice should clinical record for continuity of ed. "I would say yes."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING _		ļ	C <b>30/2016</b>	
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP CODE  9101 BON AIR CROSSINGS DRIVE  BON AIR, VA 23235				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 514	interview was cond staff member) #2, the asked how facility is going on with respectives if notes are record from the host that nursing gets a when asked how the facility of care for a reside the care plan from placed on the clinic hospice will give a then the facility will ASM #2 stated that time for the facility plan from the company. Review of the hospice company, part, the following: FACILITY with a company, the following: FACILITY with a company, the following: FACILITY with a company the Resimill furnish. HOSP patient's record the metEach party is such communication records to ensure the Patient are metH frequent communic provide FACILITY the ensure that the product this agreement and the product this agreement communication and the product this agreement communication and the product that the product this agreement communication and the product this agreement communication and the product that the product that the product this agreement communication and the product that the product that the product that the product this agreement communication and the product that the product tha	oximately 1:00 p.m., an ucted with ASM (administrative he director of nursing. When staff is supposed to know what sidents receiving hospice e not placed on the clinical spice company, ASM #2 stated verbal report from hospice. he facility determines the plan nt receiving hospice services if the hospice company is not rail record, ASM #2 stated that verbal report to the facility and develop their own care plan. It seven days was a reasonable to receive the hospice care bany.  Indice contract from (name of for Resident #9 documents in "HOSPICE shall provide popy of the Hospice plan of care dential Services that FACILITY ICE shall document in the at this requirement has been responsible for documenting ons in its respective clinical that the needs of the Hospice ospice shall promote open and cation with FACILITY and shall with sufficient information to ovision of Residential Services ent is in accordance with the re, assessments, treatment	F 51	4			
	No further informat	tion was provided prior to exit.				_	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDENSUPPLIERCIA (X2) MULTIPLE CONSTRUCTION

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495394	B. WING	S			C / <b>30/2016</b>	
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF BON AIR				,	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00	3072010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETIO DATE	×
F 514	minimize severe pobtained from Day 11th edition, p. 84 (2) Ativan-depress to decrease anxie information was of Guide for Nurses, 3. The facility star #4's clinical record resident's document Resident #4 was a 8/15/14 with diagrout limited to; hyp function), high blo (an irregular heart the eyes), aortic sartery to the heart Resident #4's moset) was a quarter (assessment referes Resident #4 was a 15 on the Brief Int (BIMS), indicating cognitively impaired on 6/29/16 at appof Resident #4's addocuments belong (Resident #9). The (occupational their sheet.	ate- opioid analgesic used to pain. This information was vis's Drug Guide for Nurses, 3.  ses the central nervous system ty or used as a sedative. This btained from Davis's Drug 11th edition, p. 763.  If failed to ensure that Resident did not include another entation.  admitted to the facility on noses that included, but were othyroidism (low thyroid od pressure, atrial fibrillation theat), glaucoma (a disease of tenosis (a disease of the main ), and dementia.  Ist recent MDS (minimum data rly assessment with an ARD rence date) of 4/28/16.  Coded as a five out of a possible terview for Mental Status that the resident was severely	F	514				
	conducted with LF the floor nurse. L	PN (licensed practical nurse) #2, PN #2 was asked who was acing documents into the clinical						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG	COM	(X3) DATE SURVEY COMPLETED	
		495394	B. WING _		ì	C 30/2016	
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 514	physician order she narcotic sheets into know who else place LPN #2 was shown to Resident #9 that LPN #2 was asked paperwork should record. LPN #2 stachart."  On 6/29/16 at 9:50 conducted with AS member) #4, the a ASM #4 was show to verify that Resid the wrong chart. A confirmed that it would be in there, I would have a shown to be in the side that it would be side that it wo	age 50 ated that the nurses put the eets, telephone orders and the othe record and she did not ced documents into the record. In the two documents belonging to were in Resident #4's record. If (name of Resident #9's) be in Resident #4's clinical ated, "No they are in the wrong a.m. an interview was M (administrative staff ssistant director of nursing. In Resident #4's clinical record lent #9's documentation was in ASM #4 reviewed and as. ASM #4 stated, "It should till take care of this right now."  Setting was held on 6; /29/16 at M #1, the administrator, ASM nursing and ASM #3, the expecialist. The staff was made of the above findings. No other ovided prior to the end of the	F 5′	14			
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