PRINTED: 04/04/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495423	B. WING		C 03/04/2040		
	ROVIDER OR SUPPLIER  / REHABILITATION AN	D HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225			03/01/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	An unannounced M survey was conduct are required for con Federal Long Term  The census in this 138 at the time of the consisted of 11 resi Self-Determination CFR(s): 483.10(f)(1 §483.10(f) Self-determination CFR(s): 483.10(f) Self-de	ledicare/Medicaid abbreviated ted on 3/1/2019. Corrections appliance with 42 CFR Part 483 Care Requirements.  196 certified bed facility was ne survey. The survey sample dent record reviews.  )-(3)(8)	F 000	1. Resident # 2 wa interviewed reg shower preferei residents showe	arding nce and er		
	promote and facilita through support of r not limited to the rig (1) through (11) of the second of t	esident has a right to choose s (including sleeping and th care and providers of health stent with his or her interests, plan of care and other		schedule was acher preference.  2. All residents har potential to not shower prefere honored. An interest was conducted residents by the designee to assoresidents show preferences harmet.  3. All nursing staff and CNA) were by the DCS or Completed by c	ve have nces erview on all e DCS or ure er ve been (RN, LPN, educated designee late ent's rights		

Any do cency statement ending with an assetiat (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sareguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495423	B. WING _		C 03/01/2019	
	ROVIDER OR SUPPLIER	D HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225		
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F 561	interfere with the rig facility. This REQUIREMEN by: Based on staff interclinical record reviet the facility failed to edetermination for or sample of 11 Resident.  1. For Resident #2 Resident to determination for a sample of 11 Resident to determination refusal of a shift the refusal as a "beliad to be facility on 12/4/1 limited to muscle we falls, insomnia, stroid diabetes Hemiplegia stroke.  Resident #2's most MDS (screening too assessment dated 2 having a (Brief Inter of 13 indicating mild on 3/1/19 at 10:45 this surveyor and ex Resident #1's care. Resident #1's care. Resident #1's care. Resident ye should be stroked about he cleaned up. She st	hts of other residents in the  IT is not met as evidenced  rview, resident interview, w and facility documentation ensure Resident right to self he Resident (#2) in a survey ents.  the facility failed to allow ne when she can shower and ower at 4:15 AM they labeled havior."  e:  rear old woman admitted to 8 with diagnoses of but not eakness fatigue, history of ke, Major depressive disorder a and Hemiparesis following  recent (Minimum Data Set) bl) coded as an admission 2/22/19 coded the Resident as view of Mental Status) BIMS d cognitive impairment.  a family member approached kpressed concern over She stated she was the	F.S	4. QI monitoring we done by the DCS/Designee to residents shown preferences are three times were one month, the per week for two QI monitoring we reported to the committee month period of 3 monitoring further compliance revision.  5. Date of Compliance 4/2/19	o ensure er honored ekly for n one time o months. vill be RM/QI thly for a ths for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUIL		X2) MULTIPLE CONSTRUCTION L BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ID HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225			03/01/2019	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 561	conducted. Reside here in the middle shower because it on to say that she showering at that it showers between She also stated showers Note stated Sh. 2/28/19 a clinic Progress Note stated 3/1/19 4:15 AM- Br. Resident advised to day. Resident advised to take in the middle of the she is on the 11 pr. she's able to take in the middle of the she is on the 11 pr. she's able to take in the middle of the she is on the 11 pr. she's able to take in the middle of the she is on the 11 pr. she's able to take in the middle of the she is on the 11 pr. she's able to take in the sident she when the sident that skipp conducive to proper attempted to reason be able to get back have to stay up. F. Staff asked when the stated in the shower in the early stated in the early stated in the shower in the early stated in the would have shower and Notify	Resident #2 was then ent #2 stated, "They come in the night and tell me I need a s my shower day." She went told them she would not be time that she would like her 7:00 and 8:00 in the morning. e didn't get her meds on time.	F 5	61			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495423	B. WING_			C 03/01/2019	
	ROVIDER OR SUPPLIER	ND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 7246 FOREST HILL AVE RICHMOND, VA 23225	ODE	03/01/2019	
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F 561	notified."  3/1/19 4:26 AM- B Addendum: Documesident is own RF On 3/1/19 an inter Administrator and showers given on responded that the When asked what showers she responded that the When asked being given at 4 air know who that is a why. When he was Resident was he sperson I was think.  The DON and Adminote dated 3/1/19 stated that's not right we can see about DON stated we can showers. When a who is her own Resident was her own Resident a "B stated it should no she has the right to On 3/1/19 an inter Employee O (Soci that she felt this will resident to get up should not be label that the resident is	ehavior Note nentation correction that and aware. MD aware.  view was conducted with the the DON When asked are any particular shift the DON ey were given on all shifts. time the night shift starts their onded between 500 and 530 was she aware of showers on the Administrator stated yes I and they get up that early that's is informed of who this stated no that's not the same	F	561			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			E SURVEY IPLETED
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200000000000000000000000000000000000000	ROVIDER OR SUPPLIER	ND HEALTHCARE	7246	EET ADDRESS, CITY, STATE, ZIP CODE FOREST HILL AVE HMOND, VA 23225	According to	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE
	meeting with her to schedule."  On 3/1/19 at the e Administration was new information. Personal Privacy/CFR(s): 483.10(h) §483.10(h) Privacy The resident has a confidentiality of his records. §483.10(h)(l) Personaccommodations, telephone communiand meetings of fathis does not requiprivate room for easients right to pright to privacy in his written, and electrothe right to send a mail and other letter materials delivered including those dethan a postal service §483.10(h)(3) The and confidential personal and meeting the personal and meeting the service for the right to send a mail and other letter materials delivered including those dethan a postal service for the resident has of personal and meeting the service for the resident has of personal and meeting the service for the resident has of personal and meeting the service for the resident has of personal and meeting the service for the resident has of personal and meeting the service for the resident has the service for the r	She further stated "I will be of fix this issue with the shower and of day conference the smade aware and offered no (Confidentiality of Records (1)-(3)(i)(ii)  I and Confidentiality, a right to personal privacy and is or her personal and medical onal privacy includes medical treatment, written and nications, personal care, visits, mily and resident groups, but re the facility to provide a ach resident.  I facility must respect the resonal privacy, including the his or her oral (that is, spoken), onic communications, including and promptly receive unopened ears, packages and other if to the facility for the resident, livered through a means other oce.  I resident has a right to secure earsonal and medical records. Is the right to refuse the release edical records except as (0(i)(2) or other applicable	F 561	1. Resident # 10 was in another room the replacement hospice. Resident #6 and #7 nurse wimmediately educand residents me information was selected and residents have potential to be af An audit was comto ensure no other observations of famaintain privacy of medical records a residents. No other residents were affected and requirements relaprivacy screens we passing medication on regident rights to dignity and privacy screens who is a privacy screen with the p	pending bed from t #4, #5, was cated dical secured. e fected. apleted er ailure to of and er fected. sed staff HIPAA ated to when ons and a related vacy arch 25, ctor of and the	

NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE    X4)   ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
BONVIEW REHABILITATION AND HEALTHCARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  (D PROVIDER'S PLAN OF CORRECTION	(XS) COMPLETION
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE ΑΡΡΡΟΡΡΙΑΤΕ DEFICIENCY	4
F 583  Continued From page 5  (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview, and clinical record review the facility staff falled to ensure privacy for 1 Resident (Resident # 10) and falled to maintain privacy of clinical records for 4 residents (Residents # 4, 5, 6, and 7) in a survey sample of 11 residents.  1. For Resident # 10 the Resident was observed in the hallway sleeping in a hospital bed for an hour and haif.  2. For Resident # 4, the facility staff left the Medication Administration Record open for view and unattended during medication pass and pour.  3. For Resident # 5, the facility staff left the Medication Administration Record open for view and unattended during medication pass and pour.  4. For Resident # 6, the facility staff left the Medication Administration Record open for view and unattended during medication pass and pour.  5. For Resident # 7, the facility staff left the Medication Administration Record open for view and unattended during medication pass and pour.  The Findings Include:  1. For Resident # 10 the Resident was observed	e

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		495423	B. WING			03/01/2019		
	ROVIDER OR SUPPLIER	ND HEALTHCARE	724	REET ADDRESS, CITY, STATE, ZIP CO 16 FOREST HILL AVE CHMOND, VA 23225	DE			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE BE APPROPRIATE	(X6) COMPLETION DATE		
F 583	the 4/29/18 with di Parkinson Disease heart beat), Major Dysphagia, and Co On 3/1/19 at 10:00 Resident # 10 was asleep in a hospital On 3/1/19 at 10:10 near elevator. Ver facility to install a "which room he wa pointed to the Res am not sure of the room.  On 3/1/19 at 11:30 10 to his room and bed.  On 3/1/19, an inte DON. When the DON When the DON was not was in the hallway empty rooms. The unacceptable they empty room until hasked why he sho DON stated there	S year old man was admitted to agnoses of but not limited to a gnoses of but not limited to a gnose of a gn	F 583					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED C	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225			03/01/2019	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 583	2. For Resident # Medication Admirand unattended of Resident # 4 was the facility on 10/but not limited to: Hypoglycemia, D Polyneuropathy.  The most recent quarterly assessi Reference Date of coded Resident # for Mental Status cognitive impairm limited assistance activities of daily bathing. Resident set up only for easter up only fo	end of day conference, the s made aware of issue and no	F 583				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING_	CONSTRUCTION		TE SURVEY MPLETED C	
		495423	B. WING			03/01/2019	
	ROVIDER OR SUPPLIER  REHABILITATION AN	ID HEALTHCARE	. 7	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225			
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F 583	that the nurse, RN from the medication passing medication screen visible. RN acceptable for the cart with the Medic for view. RN A stath hidden any time the During the end of administrator and I informed of the fine No further information. No further information and unattended duresident # 5 was at to the facility on 1/6 but not limited to, I extrapyramidal and Gastroesophageal Major Depressive and Vitamin Deficion. The most recent M 30 day assessment Reference Date (A coded Resident # for Mental Status) cognitive impairment extensive assistant activities of daily life On 3/1/2019 at 12	C, was observed to walk away in cart several times while his while leaving the computer IA stated that it was not nurse to leave the medication reation Record screen available ed the screen should be enurse walked away.  Bay debriefing, the facility Director of Nursing were dings.  So, the facility staff left the stration Record open for view uring medication pass and pour.  A 79-year-old female admitted 3/2019 with the diagnoses of, Diabetes, Schizophrenia with dimovement disorder, Reflux Disorder, Hypertension, Disorder, Pacemaker, Anemia. ency.  Inimum Data Set (MDS) was a set with an Assessment art with an Assessment IRD) of 1/31/2019. The MDS with a BIMS (Brief Interview score of 15/15, indicating no ent. Resident # 5 required ce of one staff person with	F 583				

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		495423	B. WING _			C 03/01/2019	
	ROVIDER OR SUPPLIER	ND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 7246 FOREST HILL AVE RICHMOND, VA 23225	DDE		
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F 583	medication cart with and. Surveyor A cart and saw the sign of the	th a medication cup in her walked past the medication creen was open to Resident # g identifying information and a ::21 PM, an interview was aff Development Nurse, (RN) A. RN A was informed I C, was observed to walk away on cart several times while one while leaving the computer N A stated that it was not nurse to leave the medication cation Record screen available ted the screen should be ne nurse walked away.	F	583			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495423	B. WING			3/01/2019	
101.811.011.011.01.001.0	ROVIDER OR SUPPLIER	ND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP C 7246 FOREST HILL AVE RICHMOND, VA 23225		0.01.2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 583	for Mental Status) cognitive impairme extensive to total a with activities of ditotal assistance of and limited assistate eating; Resident # continent of bowel.  On 3/1/2019 at 11 observed standing nurse was not at the computer screen of resident (Resident Demographic informedications was in On 3/1/2019 at 11 Registered Nurse medication cart.  On 3/1/2019 at 12 conducted with St. Registered Nurse that the nurse, RN from the medication screen visible. RI acceptable for the cart with the Medifor view. RN A standiden any time the During the end of administrator and informed of the fire	6 with a BIMS (Brief Interview score of 13/15, indicating no ent. Resident # 6 required assistance of one staff person aily living except she required two staff persons for transfers ance of one staff person for 16 was coded as always and bladder.  126 AM, three residents were at the medication cart. The he medication cart. The open with the name of a transfer with the name of a transfer with the name of a transfer with the screen.  129 AM, observed nurse, (RN) C, returned to the screen.  121 PM, an interview was aff Development Nurse, (RN) A. RN A was informed to C, was observed to walk away on cart several times while one while leaving the computer NA stated that it was not nurse to leave the medication cation Record screen available and the screen should be the nurse walked away.  Iday debriefing, the facility Director of Nursing were	F 58	3			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	CONSTRUCTION		TE SURVEY MPLETED
		495423	B. WING			3/01/2019
	ROVIDER OR SUPPLIER	ND HEALTHCARE	7	TREET ADDRESS, CITY, STATE, ZIP COD 246 FOREST HILL AVE RICHMOND, VA 23225	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X6) COMPLETION DATE
F 604	Continued From p	age 11	F 604			
F 604 SS=D		om Physical Restraints (1), 483.12(a)(2)	F 604			
	§483.10(e) Respe The resident has a and dignity, includ	a right to be treated with respect				
	physical or chemic purposes of discip	right to be free from any cal restraints imposed for line or convenience, and not e resident's medical symptoms, 83.12(a)(2).				
	neglect, misapproj and exploitation as includes but is not corporal punishme any physical or ch	he right to be free from abuse, priation of resident property, and defined in this subpart. This limited to freedom from ent, involuntary seclusion and emical restraint not required to a medical symptoms.				
	§483.12(a) The fa	cility must-				
	from physical or ch purposes of discip are not required to symptoms. When indicated, the facil alternative for the document ongoing restraints.	ure that the resident is free nemical restraints imposed for line or convenience and that treat the resident's medical the use of restraints is ity must use the least restrictive least amount of time and tre-evaluation of the need for				
	Based on staff into and facility docum- ensure freedom fro	erview, clinical record review entation the facility failed to om restraints for 1 Resident survey sample of 11		Past noncompliance: no pla correction required.	n of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	D HEALTHCARE	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225				
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 604	Reported Incident) found restrained in on both side rails.  The findings include Resident #1 a 75 y facility on 12/4/18 y limited to muscle w falls, Dementia with anemia, insomnia, classified elsewher disturbances.  Resident #1's most MDS (screening to assessment dated as having a (Brief I BIMS of 2 indication). She starrived at work and report with the off gwent down the northad fallen a few darence with the off gwent down the northad fallen a few darence with the off gwent down the northad fallen a few darence with the off gwent down the northad fallen a few darence with the off gwent down the northad fallen a few darence with the off gwent down the northad fallen a few darence with the off gwent down the northad fallen a few darence with the gwent down was clowest position with bed. Resident #1 is side facing the wins stated she then yellower.	e facility reported in a (Facility FRI that the resident was the bed with a bed sheet tied ed:  ear old man admitted to the with diagnoses of but not reakness fatigue and repeated rout behavioral disturbances, Dementia in other diseases e with behavioral  t recent (Minimum Data Set) ol) coded as an admission 12/21/18 coded the Resident interview of Mental Status) g severe cognitive impairment.  erview was conducted with who discovered Resident #1 tated that on 2/15/2019 sheet counted narcotics and got going nurse. She stated she the hall because Resident #1 tays prior and she wanted to	F 604					

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NAME OF D	ROVIDER OR SUPPLIER	495423	B. WING	STREET ADDRESS, CITY, STATE, ZIP C		03/01/2019	
	BONVIEW REHABILITATION AND HEALTHCARE			7246 FOREST HILL AVE RICHMOND, VA 23225	002	,100	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 604	bedrails, trapping the waist level.  LPN D stated she the Unit manager DON. She stated was assigned to he. She stated that and CNA E stated with her assignme CNA D had alread was only schedule.  LPN D further que admitted that she bed.  On 3/1/19 at 2:00 conducted with the who stated that he the incident to the Reported Incident required. The fact interview with bot admitted to tying with the assistant that she did not do it because she conducted was notified.  The DON submitted.	the bed sheet was tied on both him in the bed with the sheet at had then untied him and called the on call manager and the that she then asked which CNA his care and was told it was CNA at she then questioned CNA E that CNA D was assisting herent and she put him to bed. By left for the evening as she ed until 7:00 PM.  Destioned CNA E and she and CNA D both tied him to the extremely and the Administrator to the Administrator	F 60	14			
	She also submitte 2/16/19 on Abuse	/23/19 on Abuse and Neglect. ed in-service sheets dated e Neglect and Physical Restraint had been in-serviced.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(2) MULTIPLE CONSTRUCTION BUILDING		TE SURVEY MPLETED	
		495423	B. WING	3. WNG		03/01/2019	
	NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			REET ADDRESS, CITY, STATE, ZIP COD 16 FOREST HILL AVE CHMOND, VA 23225		310112013	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL RR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X8) COMPLETION DATE	
F 604	was discussed and provided.  The facility submitt Correction:  1. Resident #1 w no physical or psyr. The facility immed pending investigat records for both er completed. No oth noted in the file. As received education prior to this allegationer to this allegationer to the facility has at risk of abuse. A done on all resident had bedsheets tied incidents were not resident and staff if the entire facility readditional allegation.  3. Education was staff regarding ide and neglect.	age 14 Ind of day conference this issue of no further information was led the following Plan of the sas immediately assessed and chological changes were noted. In a suspended both CNA's led to the control of the same of th	F 604	DEFICIENCY			
	allegations of abus Management will to patient observation next four weeks to and neglect, as we interviews with all	all staff. All additional se will be reported as required, be present on various shifts for a two times per week for the validate education on abuse all as conduct resident interviewable residents and ans and symptoms of abuse.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED
		495423 B. WIN			C 03/01/2019
	ROVIDER OR SUPPLIER  / REHABILITATION AND	HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECT PROPRIATE CORRECT PROVIDER		LD BE COMPLETION
	Information will be recommittee monthly for revision.  5. Date of Compliant Services Provided M CFR(s): 483.21(b)(3)  §483.21(b)(3) Comp The services provide as outlined by the comust- (i) Meet professional This REQUIREMEN' by:  Based on observation interview, staff interview, staff interview, the facility st professional standar administration for 6 of #5, #6, #7, 9, and a residents.  1. For Resident #3, administer medication parameters of time madministration.  2. For Resident #4, administer medication parameters of time madministration.  3. For Resident #5,	eported to the QAPI or further compliance and or since: 02/22/2019  e. eet Professional Standards (i)  rehensive Care Plans of or arranged by the facility, imprehensive care plan, standards of quality.  T is not met as evidenced on, resident interview, family iew, and clinical record aff failed to follow the ds of medication esidents (Residents # 3, # 4, # 2) in a survey of 11  the facility staff failed to ms within the standard egarding medication  the facility staff failed to ms within the standard egarding medication  the facility staff failed to ms within the standard egarding medication  the facility staff failed to ms within the standard egarding medication	F 60	1. Resident #2, # 3, #4, # #6, #7, #9 provider an responsible representative were	d she of ew . sed . No ere ted. ted ted to staff suring the es of March

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IX1) PROVIDER/SUPPLIER/CLIA   (X2) MULT   IDENTIFICATION NUMBER:   A. BUILDII   A		MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
					0	03/01/2019		
	ROVIDER OR SUPPLIER	ND HEALTHCARE	72	REET ADDRESS, CITY, STATE, ZIP ( 16 FOREST HILL AVE CHMOND, VA 23225		3/01/2019		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 658	4. For Resident # administer medica parameters of time administration.  5. For Resident # administer medica parameters of time administration.  6. For Resident # administer medica parameters of time administration.  7. For Resident #2 medications within medication administration.  7. For Resident #2 medications within medication administration.  7. For Resident # administer medication adminis	6, the facility staff failed to tions within the standard regarding medication 7, the facility staff failed to tions within the standard regarding medication 9, the facility staff failed to tions within the standard regarding medication 1. the facility failed to administer the standard parameters of stration. 3, the facility staff failed to tions within the standard dication administration. 4. the facility staff failed to 5/2017 with the diagnoses of, Severe Chronic Obstructive re, Sarcoidosis, Hypertension, frome following multiple car sion and anxiety, Major	F 658	4. QI monitoring done by the DCS/Designed medications a administered standard paratime three tin for one mont time per wee months. QI n will be report RM/QI comm monthly for a 3months for I compliance a revision.  5. Date of Comp 4/2/2019	e to ensure ire within the ameters of nes weekly h, then one k for two nonitoring ed to the ittee period of further nd/or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILDIN		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED C	
		495423 B. WING			0:	03/01/2019	
	NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			REET ADDRESS, CITY, STATE, ZIP COD 16 FOREST HILL AVE CHMOND, VA 23225	E		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	for Mental Status) cognitive impairmed supervision and seactivities of daily lifeating, bathing and supervision with as for transfer and be coded as always of transfer and be coded as always of the stated as always Resident # 3 state late the night befor stated he did not go but was supposed stated he was upshis breathing med stated he had 4 lift still was short of b Resident # 3 state time so I can breathing	score of 15/15, indicating no ent. Resident # 3 required at up only assistance with ving for ambulation, dressing, dotoileting and required assistance of one staff person domobility; Resident # 3 was continent of bowel and bladder.  20 AM, an interview was estident # 3 who stated the working short of staff, do he received his medications are (2/28/2019). Resident # 3 let his medication until 11 PM to get it at 9 PM. Resident # 3 let because he needed to get leations on time. Resident # 3 lets of oxygen per minute and reath because of COPD.  do "I need my medicines on the."	F 658				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDII		E CONSTRUCTION	1. K. O. K. C. C. C.	(X3) DATE SURVEY COMPLETED	
		495423 B. WIN		G		3/01/2019	
	ROVIDER OR SUPPLIER	D HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 658	On 3/1/2019 at 1:10 conducted with the Registered Nurse (If should be passed whour after the sched RNA A stated RN C approximately 3 we RN A stated "the 6 n Administration" was with all new nurses, receive 3 days of cl days on the floor wishould be directed to Development Nurse floor. RN A stated If about medication are orientation. RNA A standard was for numedications within after the scheduled that "all nurses should be directed to orientation topics of C. The list of topics orientation was not to the end of the sur On 3/1/2019 at 1:38 conducted with the the MAR showed the administered at 9 P was informed that I received his medica 2/28/2019. When the total sure of how to continue of the sure	PM. an interview was Staff Development Director, RN) A who stated medications within an hour before and an fulled time of administration, was a new employee of eks at the time of the survey, rights of Medication Istressed during orientation RN A stated new nurses assroom instruction and 3 th a nurse, then any questions to the Unit Manager or Staff for any other nurse on the RN C received the information diministration during her stated the professional nursing wirses to administer one hour before and one hour time of administration and full know that."  provide a copy of the evered with Registered Nurse scovered during RN C's provided to the surveyor prior rivey.  FM, an interview was Director of Nursing who stated the medications were M as scheduled. The DON Resident # 3 reported that he ations 2 hours late on the DON was asked for a copy	F 65				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		BUILDING		(X3) DATE SURVEY COMPLETED	
		495423	B. WING		0	03/01/2019	
	NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			REET ADDRESS, CITY, STATE, ZIP CO 46 FOREST HILL AVE CHMOND, VA 23225		0/01/2015	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 658	using the EMAR s report.  On 3/1/19 at 1:45 conducted with the Practical Nurse (L and stated that the time printed on the Resident # 3 state late on 2/28/2019 she could print ou administration sho medication admin was asked if she of information on the surveyors to use, report and got the have access to th would try one of the then went to a face EMAR Report der medications were by whom.  On 3/1/2019 at 2: of the EMAR report "Administration H medications docu according to the M were actually adm  Advair Diskus Aer 250-50 microgram times a day for Cl Disease Schedule	with giving medications and system to try to retrieve the PM, an interview was a unit manager, Licensed PN) E, who looked at the MAR a medications were given at the e MAR. When told that ad he received his medications. LPN E stated she would see if the what the actual times of own on the EMAR (electronic istration record). When LPN E could access the EMAR accomputer given to the LPN E attempted to retrieve the error message "User does not is screen." LPN E stated she had administered, signed out and administered, signed out and administered, signed out and the mented as administered on time MAR were not correct. They ministered at the times noted:  Tosol Powder Breath Activated and does one puff inhale orally two monoric Obstructive Pulmonary and at 9 PM 8 (10:58 PM) documented	F 658				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R) MULTIPLE CONSTRUCTION BUILDING		TE SURVEY MPLETED	
		495423	B. WING			C 03/01/2019	
	ROVIDER OR SUPPLIER	ND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP C 7246 FOREST HILL AVE RICHMOND, VA 23225		0.01.2010	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	mouth two times a PM for Chronic Pa 2/28/2019 at 22:5 2/28/2019 at 23:1 Ketotifen Fumara drop in both eyes AM and 9 PM rela Neuropathy Sche 2/28/2019 at 22:5 2/28/2019 at 23:1 Oxycontin Extend Abuse-Deterrent mouth every 12 h Syndrome Sched 2/28/2019 at 23:1 Senna Capsule 8 by mouth at bedtiat 9 PM 2/28/2019 at 23:1 Tylenol 325 millig hours for pain Sc PM 2/28/2019 at 23:1 On 3/1/2019 at 23:1 On 3/1/2019 at 5 reported that Potused by the facilit guidance. The Document of the process of the potused by the facilit guidance. The Document of the potused by the facilit guidance. The Document of the potused by the facilit guidance. The Document of the potused by the facilit guidance. The Document of the potused by the facility guidance. The Document of the potused by the facility guidance.	nilligrams give one tablet by a day Scheduled at 9 AM and 9 ain Syndrome 8 (10:58 PM) documented 8 (11:18 PM)  te Solution 0.025 % Instill one every 12 hours Scheduled at 9 ated to Hereditary and Idiopathic duled at 9 AM and 9 PM 8 (10:58 PM) documented 8 (11:18 PM)  led Release 12 hour 20 milligrams give one tablet by ours related to Chronic Pain uled 9 AM and 9 PM 8 (10:58 PM) documented 8 (11:18 PM)  de milligrams give one capsule me for constipation Scheduled 8 (10:58 PM) documented 8 (11:18 PM)  rams Give 3 tablets every 8 heduled at 6 AM, 2 PM and 10 44 (11:14 PM) documented	F6	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING 495423 B. WING		53565 <del></del>		(X3) DATE SURVEY COMPLETED  C 03/01/2019	
	ROVIDER OR SUPPLIER	HEALTHCARE	7246	STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	the administration of "Fundamentals of N Potter-Perry, p. 705 such as the America Nursing: Scope and Practice (2004) app administration. To proceed the six rights medication errors of an inconsistency in medication administration Date: 9/22 revealed:  "Chart on Medication (MAR) according in medication is given next resident."  During the end of the Administrator and Dinformed of the find documented on the Record as administration adminis	sional nursing standards for f medication was provided by ursing, 7th Edition, Professional standards, an Nurses Association's d Standards of Nursing by to the activity of medication prevent medication errors, of medications. Many an be linked, in some way, to adhering to the six rights of tration. The six rights of tration include the following: edication se ent ute	F 658				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A BUIL		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED C	
		495423	B. WING		0	03/01/2019	
	NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP C 246 FOREST HILL AVE RICHMOND, VA 23225	ODE		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	later than the schi 2/28/2019 and ap time according to Nursing stated the medications shoule hour before and a On 3/1/2019 at 8: Progress Notes we nurses notes reve 3/1/2019 at 20:01 (Medical Doctor/F of morning medic signed by LPN B.  On 3/1/2019 at 8: Progress Notes we nurses notes reve 3/1/2019 at 19:56 (Medical Doctor/F of morning medic signed by Register No further information 2. For Resident # administer medic parameters of med Resident # 4 was the facility on 10/ but not limited to: Hypoglycemia., D Polyneuropathy.  The most recent if	eduled time of 9 PM on opeared to have been given on the MAR. The Director of expectation was that ld be administered within one offer the scheduled time.  15 PM, a copy of the Nurses was presented. Review of the ealed documentation on (8:01 PM) that "MD/RP Responsible Party) made aware ations administered late."	F 658				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423		(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING		TE SURVEY MPLETED  C	
	ROVIDER OR SUPPLIER	2000000		STREET ADDRESS, CITY, STATE, ZIP C 7246 FOREST HILL AVE RICHMOND, VA 23225		03/01/2019	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	coded Resident # for Mental Status; cognitive impairm limited assistance activities of daily I bathing. Residen set up only for ea staff person for ba as occasionally or Review of the clin 3/1/2019 at 1:15 I  Review of the Me revealed docume administered on t and the initials of medications in the There was no docume administration of Review of the Nu 3/1/2019 revealed administration of Note was 2/28/20 "Bs (Blood Sugar On 3/1/2019 at 1 conducted with the the MAR showed administered as a asked for a copy medication admin stated she was no of the EMAR rep get a Nurse who	4 with a BIMS (Brief Interview score of 8/15, indicating severe ent. Resident # 4 required of one staff person with iving except for eating and the 4 required supervision with ting and total assistance of one athing. Resident # 4 was coded ontinent of bowel and bladder.  Idical record was conducted on PM.  Idication Administration Record intation of all medications being ime. There were check marks the nurses administering the estor for scheduled times, currentation of late medications on the MAR.  In the series of the series of the except of the except of the series of the series of the series of the except of the series of	F	558			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423		X2) MULTIPLE CONSTRUCTION  BUILDING		TE SURVEY MPLETED C
	NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP 7246 FOREST HILL AVE RICHMOND, VA 23225		3/01/2019
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 658	conducted with the Practical Nurse (I and stated that the time printed on the would see if she of times of administration LPN E was EMAR information surveyors to use, report and got the have access to the would try one of the then went to a face EMAR Report demedications were by whom.  On 3/1/2019 at 2 of the EMAR report and got the EMAR report and got the medications document at the times note. Ascorbic Acid Tall time a day Schedus 3/1/2019 administration Emperications and the times note. Aspirin 81 millignation and a day Schedus 3/1/2019 administration Emperication Schedus and Schedus 3/1/2019 administration Emperications document and the times note. Aspirin 81 millignation and the times deficiency Schedus deficiency Schedus Sched	PM, an interview was e unit manager, Licensed LPN) E, who looked at the MAR e medications were given at the e MAR. LPN E stated she could print out what the actual ration showed on the EMAR ation administration record). Is asked if she could access the n on the computer given to the LPN E attempted to retrieve the e error message "User does not his screen." LPN E stated she he facility's computers. LPN E cility computer and printed he noting the exact times the e administered, signed out and  102 PM, LPN E presented a copy out. Review of the EMAR listory Report" revealed umented as administered on time MAR were actually administered d: older 500 milligrams by mouth one duled for 9 AM stered at 10:39 AM ams one tablet by mouth one	F 65	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 03/01/2019	
		495423	B. WING				
	ROVIDER OR SUPPLIER	ND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225			0/01/2013	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	PM)  Humalog Insulin pounits, 201-250= 6 and 301-350= 12 units, subcutaneously be related to Diabetes PM and 9 PM  2/27/2019 at 11:47  Review of the Faci Medications -Oral, Procedures Effecti Revision Date: 9/2 revealed:  "Chart on Medicati (MAR) according it medication is given next resident."  During the end of the Administrator and informed of the find documented on the Record as adminisheing given on time medications listed later than the sche Nursing stated the medications should hour before and or time.  On 3/1/2019 at 8:1	er sliding scale: If 151-200 = 3 units, 251-300= 9 units, 351-400= 15 units, efore meals and at bedtime s Scheduled 6 AM, 11 AM, 4	F 658				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C		
	NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE		B. WING	STREET ADDRESS, CITY, STATE, ZIP 6 7246 FOREST HILL AVE RICHMOND, VA 23225		03/01/2019	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES JENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(Xb) COMPLETION DATE	
F 658	nurses notes rew 3/1/2019 at 19:56 (Medical Doctor/f of morning medic this morning." sig No further inform  3. For Resident: administer medic parameters of me Resident # 5 was to the facility on a but not limited to extrapyramidal a Gastroesophage Major Depressive and Vitamin Defi The most recent 30 day assessme Reference Date coded Resident: for Mental Status cognitive impairm extensive assists activities of daily  Review of the cli 3/1/2019.  Review of the Mi Administration R administered on check mark indic administered. The	ealed documentation on (7:56 PM) that "MD/RP Responsible Party) made aware sations were administered late ned by RN B.  ation was provided.  # 5, the facility staff failed to sations within the standard edication administration.  8 a 79-year-old female admitted 1/3/2019 with the diagnoses of, Diabetes, Schizophrenia with and movement disorder, all Reflux Disorder, Hypertension, a Disorder, Pacemaker, Anemia. ciency.  Minimum Data Set (MDS) was a cent with an Assessment (ARD) of 1/31/2019. The MDS # 5 with a BIMS (Brief Interview s) score of 15/15, indicating no nent. Resident # 5 required ance of one staff person with	F6	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD  495423 B. WING		E CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED  C 03/01/2019	
	ROVIDER OR SUPPLIER  REHABILITATION AND	HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 658	administered during Registered Nurse (R medications to Reside Review of the Nurse 3/1/2019 revealed not administration of me Note was from Activi (1:30 PM) stating "P Note: (Resider participate in group spending time in roo friendly conversation Signed by Activities the Activities note we 2/21/2019 at 1:50 All On 3/1/2019 at 1:50 All On 3/1/2019 at 1:50 All Conducted with the SRegistered Nurse (R should be passed whour after the sched RNA A stated RN C approximately 3 week RN A stated the 6 right Administration was swith all new nurses. receive 3 days of cladays on the floor with should be directed to Development Nurse floor. RN A stated Fabout medication accordination. RNA A standard was for nurmedications within contentation within contentations	edications scheduled to be the time the nurse, N) C was observed passing dent # 5 on 3/1/2019.  Is Notes from 2/1/2019 to a documentation of late dications. The last Progress ties on 2/22/2019 at 13:30 articipation of # 5) does not wish to programs and enjoys of moreover watching tv. She likes at times. No concerns. Director. The note prior to as a Skilled Nurse Note dated with the state of the survey. The number of administration was a new employee of each at the time of the survey. The stressed during orientation and 3 the nurse, then any questions to the Unit Manager or Staff or any other nurse on the RN C received the information diministration during her stated the professional nursing rises to administration and one hour time of administration and interesting of administration and interesting of administration and one hour time of administration and	F 65				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495423  NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE		IDENTIFICATION NUMBER: A. BUILI		(2) MULTIPLE CONSTRUCTIONBUILDING		(X3) DATE SURVEY COMPLETED C	
		495423	B. WING		0	03/01/2019	
			STREET ADDRESS, CITY, STATE, ZIP 7246 FOREST HILL AVE RICHMOND, VA 23225	CODE			
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	orientation topics C. The list of topic orientation was not to the end of the second conducted with the MAR showed administered as a saked for a copy medication administered as a saked for a copy medication administered she was not the EMAR reported a Nurse who medications and retrieve the reported on 3/1/19 at 1:45 conducted with the Practical Nurse (I and stated that the printed on the RN C was observed the actual times of EMAR (electronic record). When Li access the EMAR given to the survererieve the reportive of the survererieve the reportive of the work computers. LPN	to provide a copy of the covered with Registered Nurse cs covered during RN C's of provided to the surveyor prior survey.  35 PM, an interview was be Director of Nursing who stated the medications were scheduled. When the DON was not the EMAR (electronic histration record) report, she of sure of how to obtain a copy ort. The DON stated she would was familiar with giving using the EMAR system to try to	F 65	W			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		
		495423	B. WING			C 03/01/2019	
	IDER OR SUPPLIER	ND HEALTHCARE		STREET ADDRESS, CITY, STATE, 7246 FOREST HILL AVE RICHMOND, VA 23225	ZIP CODE	00/01/2013	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		
Or of "A min act at As min Sc 3/ Att min Sc 3/ Butin Sc 3/ Lo tin 3/ Tr every Pf 3/ Zo tin	the EMAR report dministration His edications docur coording to the Mithe times noted: spirin EC (Enterioligrams one table the duled at 9 AM 1/2019- administrated at 9 AM 1/2019- administrated to constipate a day for Aller 1/2019- administrated to constipate a day for Aller 1/2019- administrate a day for Aller 1/2019- administrate a day for Aller 1/2019- administrate at the constipate at the constitution of the constitution	22 PM, LPN E presented a copy rt. Review of the EMAR story Report" revealed mented as administered on time IAR were actually administered c Coated) Delayed Release 81 let by mouth one time a day. Mered at 12:03 PM Illigrams give one tablet by day for Hyperlipidemia Mered at 12:03 PM rams one tablet by mouth one for depressive disorder. Mered at 12:03 PM grams one tablet by mouth one for depressive disorder. Mered at 12:03 PM grams one tablet by mouth one for depressive disorder. Mered at 12:03 PM grams one tablet by mouth one for depressive disorder at 9 AM for mouth two times a day tion Scheduled at 9 AM for mouth two times a day tion Scheduled at 9 AM for mouth two times a day tion Scheduled at 9 AM for mouth at 12:03 PM for mouth and 9 for Depressive Disorder	F	358			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING	E CONSTRUCTION		TE SURVEY MPLETED		
		495423	B. WING			03/01/2019		
11000-0100-07-0100	ROVIDER OR SUPPLIER	D HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES RCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X6) COMPLETION DATE		
F 658	Review of the Facili Medications - Oral A Procedures Effectiv Revision Date: 9/22 revealed: "Chart on Medicatio (MAR) according immedication is given next resident."  On 3/1/2019 at 3:30 conducted with RN acceptable for medication adminis "talked with the stall the other shifts too stress medication a orientation of new edication administrator and Different on the Record as administrator and Different on the Record as administrator and Different on the Record as administration of the Record as administration ad	ty Documentation on administration Policies and the Date: 11/30/2014 and ty/2017 on page 1 of 2 on Administration Record and before proceeding to the DPM, an interview was A who stated it was not ications to be given 3 hours the planned to provide rising staff about proper tration. RN A stated she had find on duty now and will educate "RN A stated she would administration standards during"	F 656					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING_	505.0 ST COLO V		TE SURVEY MPLETED C
		495423	B. WNG		0	3/01/2019
NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE		72	REET ADDRESS, CITY, STATE, ZIP 146 FOREST HILL AVE ICHMOND, VA 23225	CODE		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 658	3/1/2019 at 19:57 (Medical Doctor/F of late administra (medications)." si  No further information  4. For Resident # administer medicing parameters of medications and the facility on 1 but not limited to, Contractures of Resident # Diabetes, Hemiple Ulcer of Left Hee  The most recent an admission assisted Resident # for Mental Status cognitive impairment extensive to total with activities of total assistance of and limited assistent parameters of the continent of bower.  Review of the climitation Review of the MacAdministration Review o	ealed documentation on (7:57 PM) that "MD/RP Responsible Party) made aware tion of morning meds gned by RN B.  ation was provided.  # 6, the facility staff failed to ations within the standard edication administration.  # an 83-year-old female admitted 1/25/2019 with the diagnoses of, Atherosclerotic Heart Disease, eft elbow and left hand, legia, Tinea Corporis, Pressure I, and Hypertension.  Minimum Data Set (MDS) was ressment with an Assessment (ARD) of 2/1/2019. The MDS # 6 with a BIMS (Brief Interview and sistance of one staff person daily living except she required of two staff persons for transfers tance of one staff person for # 6 was coded as always	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDIN:  495423 B. WING_		50-73-73-75		(X3) DATE SURVEY COMPLETED C	
	ROVIDER OR SUPPLIER	20 27 20 24		STREET ADDRESS, CITY, STATE, ZIP C		13/01/2019	
(X4) ID PREFIX TAG	(EACH DEFICH	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	check mark indica administered. The late administered in late administration of administered during Registered Nurse medications to Reserview of the Nurdocumentation of medications.  On 3/1/2019 at 2:: Nurse (LPN) Expression of medications.  On 3/1/2019 at 2:: Nurse (LPN) Expression of medications.  On 3/1/2019 at 2:: Nurse (LPN) Expression of medications.  Anister (LPN) Expression of medications.  Anister (LPN) Expression of medications.  Amister (LPN) Expression of medications.  Amiste	ting the medications were ere was no documentation of of medications. There was no medications scheduled to be not the time the nurse, (RN) C was observed passing sident # 6 on 3/1/2019.  The ses Notes revealed no late administration of the EMAR "Administration of the EMAR "Administration evealed medications dministered on time according actually administered at the ligrams give one tablet by day Scheduled at 9 AM stered at 11:17 AM stered at 10:39 AM stered at 10:39 AM illigrams give one tablet by day Scheduled ay 9 AM stered at 11:17 AM stered at 11:17 AM stered at 11:17 AM stered at 10:39 AM in Insulin inject 10 units one time a day for Diabetes	F 658				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION		TE SURVEY MPLETED C
		495423	B. WING _	B. WING		03/01/2019
	ROVIDER OR SUPPLIER	D HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 7246 FOREST HILL AVE RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 658	2/28/2019 administ	tered at 10:39 AM	F6	558		
	Medications -Oral. Procedures Effecti Revision Date: 9/2 revealed: "Chart on Medicati (MAR) according in	lity Documentation on Administration Policies and ve Date: 11/30/2014 and 2/2017 on page 1 of 2 ion Administration Record mmediately [sic] following when and before proceeding to the				
	conducted with RN acceptable for me A stated she plann nursing staff about administration. RI the staff on duty n shifts too." RN As importance of adh	30 PM, an interview was NA who stated it was not dications to be given late. RN and to provide education to the tropper medication NA stated she had "talked with low and will educate the other stated she would stress the ering to the standards of estration during orientation of swell.				
	Administrator and	the day debriefing, the Director of Nursing were dings of medications being			120	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	co	(X3) DATE SURVEY COMPLETED  C 03/01/2019	
	NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP O 7246 FOREST HILL AVE RICHMOND, VA 23225		370172019	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	documented on the Record as administer medications with administer medication and time.  On 3/1/2019 at 8 Progress Notes on the nurses notes revisited by RN C No further informs  5. For Resident #7 administer medications with administer medications should be a support of morning medications.  For Resident #7 administer medications and and parameters of medications.  Resident #7, a stocked to the facility 11/2 included but well malignant Neoperson th	the Medication Administration istered on time but actually not me within the parameters of instration of within one hour our after the scheduled time. The divere given more than one hour needuled time. The Director of the expectation was that add be administered within one one hour after the scheduled was presented. Review of the realed documentation on 0 (8:10 PM) that "MD/RP Responsible Party) made aware cations were administered late."  The facility staff failed to cations within the standard redication administration.  If the facility staff failed to cations on time within the eters of medication was admitted to cations on time within the eters of medication.  So year old female, was admitted to see the party of the uterus, vitamin D mia, Edema, Bariatric Surgery,	F 65	8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED C	
					۱ ۵	03/01/2019	
	NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			REET ADDRESS, CITY, STATE, ZIP CO 46 FOREST HILL AVE CHMOND, VA 23225		5/01/2015	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSG IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(XB) COMPLETION DATE	
F 658	Resident #7's mos set) with an ARD (12/5/2018 was con assessment. Resident #15 out of 15 ind and was able to make decisions. Resident #15 out of 15 ind and was able to make decisions. Resident #16 was and ambulation.  On 3/1/2019 at 11 record for Resident #17 was and ambulation.  On 3/1/2019 at 11 record for Resident #17 was and ambulation.  Review of the Med (MAR) for March 2 medications that with the MAR revealed one medication do observed to be add (Depakote 500 minum All of the other minum Resident #17 were as morning (6 AM) evening medication were PRN (as need to a medicat	age 35 at recent MDS (minimum data assessment reference date) of ded as an admission ident # 7 was coded as having review of Memory Status) Score icating no cognitive impairment take her own daily life and # 7 was coded as requiring assistance of one staff in her activities of daily living to toleting, hygiene and bathing, coded as independent in eating, and that # 7 was conducted.  State of the clinical and the foliation of the ead of the foliation of the ead of the foliation of the eat the time the nurse was ministering medications to her eat the time the nurse was ministering medications to her eat the time the nurse was ministering medications to her eat the time the nurse was ministering medications to her eat the time the nurse was ministering medications to her eat the time the nurse was ministering medications to her eat the time the nurse was ministering medications to her eat the time the nurse was ministering medications to her eat the time the nurse was ministering medications to her eat the time the nurse was ministering medications to her eat the time the nurse was ministering medications or the eat the time the nurse was ministering medications ordered.  Each of the foliation of the each of the each of the medications with the each of the medications with the equested. The March 2019 all medications were given on	F 658				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILDII		MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED		
		495423 B. WING			، ا	03/01/2019		
	ROVIDER OR SUPPLIER	HEALTHCARE	724	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 658	documentation on the Administration Reco-Levetiracetam, Loral were given on time a checkmarks indicating administered on time documentation of melate administration.  Further review of the Clorazepate 7.5 milling hours was not schedule hours at 6 AM, 2 PM.  Review of the Programotes documenting I medications. The la Activities on 2/22/20 "Participation Note: participates as tolerano concerns" Signature of the mote prior to the an "eMAR-Medication 2/16/2019 at 14:42 (4 milligrams was given on 3/1/2019 at 2:02 Nurse (LPN) E presereport. Review of the History Report" reverdocumented as administration on the prior of the commented as administration of the prior to the commented as administration of the commented as administ	#7's clinical record revealed e March 2019 Medication rd that medications (Lasix, adine, Potassium Chloride) at 9 AM. There were ag medications were e. There was no missing edications or any indication of edications or any indication at 9 edications on every 8 and 10 PM each day.  Eass Notes revealed no nurses ate administration of est Progress Note was from 19 at 13:27 (1:27 PM) stating (Resident # 7) edicated and self directs in room. Edication edication in edication in edication in edication in edication edication.  Activities Progress Note was edicated and self directs in room. Edication edication edication edication.  PM, Licensed Practical ented a copy of the EMAR edications.	F 658					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		<b>495423</b> B. WING.		NG		C 03/01/2019	
	ROVIDER OR SUPPLIER	ID HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 7246 FOREST HILL AVE RICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE	
F 658	PM on 2/28/2019 a given on 3/1/2019 Documentation she medications were a 3/1/2019 at 5:52 P Clorazepate 7.5 m every 8 hours for 0 (Scheduled 6 AM, Depakote 500 millie every 6 hours for e (Scheduled 6 AM, Midnight) Tegretol 200 millig for Seizures (Scheduled 6 AM, Midnight) Tegretol 200 millig for Seizures (Scheduled 6 AM, Midnight) Tegretol 200 millig for Seizures (Scheduled 6 AM, Midnight) Tegretol 200 millig for Seizures (Scheduled 6 AM, Midnight) Tegretol 200 millig for Seizures (Scheduled 6 AM, Midnight) Tegretol 200 millig for Seizures (Scheduled 6 AM, Midnight) Tegretol 200 millig for Seizures (Scheduled 6 AM, Midnight) Tegretol 200 millig for Seizures (Scheduled 6 AM, Midnight) Tegretol 200 milligrams a day for edema Levetiracetam 750 two times a day for seizure and da	nedications scheduled for 10 and 3/1/2019 at 6 AM were both at 5:52 AM.  owed two doses of these given at the same time on M.  illigrams one tablet by mouth Generalized Anxiety Disorder 2 PM, and 10 PM grams one tablet by mouth overy 6 hours for Seizures 12 noon, 6 PM and 12  rams by mouth every 8 hours duled 6 AM, 2 PM, and 10 PM)  fulled to be administered on overe administered at 11:31 AM 100 milligrams one tablet by day scheduled at 9 AM 2019 at 11:31 AM 10:00 sone tablet by mouth one time of milligrams one tablet by mouth or Epilepsy grams one tablet by mouth one	F6	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495423 B. WING			0	03/01/2019	
	ROVIDER OR SUPPLIER  / REHABILITATION A	ND HEALTHCARE	7	TREET ADDRESS, CITY, STATE, ZIP CO 246 FOREST HILL AVE RICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE SE APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From p	age 38	F 658				
	"Chart on Medicat (MAR) according i medication is give next resident."  On 3/1/2019 at 3:: conducted with RI acceptable for me A stated she plann nursing staff abou administration. Ri the staff on duty is shifts too." RN A medication admin orientation of new  During the end of the Administrator informed of the fin documented on th Record as admini being given on tim medications listed later than the sche Nursing stated the medications shou hour before and of time. The Director should administer physician.  On 3/1/2019 at 8; Progress Notes w nurses notes reve 3/1/2019 at 20:01	tion Administration Record immediately [sic] following when in and before proceeding to the 30 PM, an interview was NA who stated it was not dications to be given late. RN ned to provide education to the it proper medication. NA stated she had "talked with low and will educate the other stated she would stress istration standards during employees as well.  The day debriefing on 3/1/2019, and Director of Nursing were adings of medications being the Medication Administration stered on time but actually not the within the parameters of istration of within one hour after the scheduled time. The lawere given more than one hour eduled time. The Director of the expectation was that lid be administered within one hour after the scheduled or of Nursing stated nurses are medications as ordered by the sealed documentation on (8:01 PM) that "MD/RP Responsible Party) made aware	F 636				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GUIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			TE SURVEY MPLETED	
		495423	B. WING		١,	C 03/01/2019	
	ROVIDER OR SUPPLIER  REHABILITATION A	ND HEALTHCARE	7246	EET ADDRESS, CITY, STATE, ZIP CO FOREST HILL AVE HMOND, VA 23225		370 1720 15	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 658	"argumentative at should be at other No further information."  6. For Resident # administer medical parameters of time administration.  Resident # 9, a 72 the facility 10/5/20 included but were Disease. Tremor, Thrombosis, Benit Urinary Tract Sym Hypertension, Dys. Abnormalities of C.  Resident # 9's modern Set) with an Asset 1/12/2019 was concluded as assistance of one activities of daily I.  Review of the clin 3/1/2019 at 4:30 F.  Review of the MA Record) revealed on time on 2/28/20	d 3/1/2019 at 15:02 (3:02 PM) bout medications and why they r times." signed by RN C. ation was provided.  9, the facility staff failed to ations within the standard e regarding medication  2 year old male, was admitted to 018. Resident # 9's diagnoses not limited to: Parkinson's Chronic Embolism and gn Prostate Hyperplasia without aptoms, Hyperlipidemia, Anxiety, sarthria, Anarthria, and Gait and Mobility.  1 st recent MDS (Minimum Data assment Review Date of ded as a quarterly assessment. MS (Brief Interview for Mental as coded as a 6 out of 15 cognitive impairment. Resident needing limited to total staff member to perform his iving.	F 658				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILDIN		2000-2000 <del></del>		(X3) DATE SURVEY COMPLETED	
		495423	B. WING			03/01/2019	
	ROVIDER OR SUPPLIER  / REHABILITATION AN	ID HEALTHCARE	724	EET ADDRESS, CITY, STATE, ZIP CODE 6 FOREST HILL AVE CHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE	
F 658	administered. The late administration  On 3/1/2019 at 5:1 A presented a copy of the EMAR "Administered on time actually administered on the comparison of the comparison	ere was no documentation of of medications.  O PM, Registered Nurse (RN) by of the EMAR report. Review inistration History Report ons documented as me according to the MAR were red at the times noted:  In significant of the significant of th	F 658				

		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495423 B. WIN				03/01/2019	
	ROVIDER OR SUPPLIER	HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From pag	e 41	F 6	58			
	Oxybutynin Chloride by mouth every 8 ho Hyperplasia Scheduled 2/28/2019 3/1/2019 at 1:32 AM Senna 8.6 milligrams bedtime for Constipe Scheduled 2/28/2019 3/1/2019 at 1:32 AM Monitor vital signs ex Scheduled 2/28/2019 3/1/2019 at 1:32 AM During the end of the the Administrator and informed of the finding documented on the IRecord as administration administration administration administration administration before or one hour a medications listed what later than the scheduled Nursing stated the emedications should hour before and one time. The Director of should administer mighysician.  No further information of the IRecord as administer mighysician.	5 milligrams give one tablet urs for Benign Prostatic  9 at 9 PM, administered  5 give two tablet by mouth at attion  9 at 9 PM, administered  very 12 hours  9 at 9 PM, documented  6 day debriefing on 3/1/2019, di Director of Nursing were ngs of medications being Medication Administration ered on time but actually not within the parameters of ration of within one hour after the scheduled time. The ere given more than one hour uled time. The Director of eadministered within one administered within one in hour after the scheduled of Nursing stated nurses edications as ordered by the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495423 B.V			1 1	03/01/2019	
	ROVIDER OR SUPPLIER	DHEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 7246 FOREST HILL AVE RICHMOND, VA 23225		00/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From page	(42,225 °C)	F6	58			
	to the facility on 12/ limited to muscle we falls, insomnia, stroi	ear old woman, was admitted 4/18 with diagnoses of but not eakness fatigue, history of ke, Major depressive disorder a and Hemiparesis following					
	MDS (screening too assessment dated 2 Resident as having	recent (Minimum Data Set) il) was coded as an admission 2/22/19. The MDS coded the a (Brief Interview of Mental indicating mild cognitive					
		M, an observation was made edications to residents.					
	Resident # 2 did no	I Record review revealed that t have medications due at the served passing medications.					
	(Medication Administrequested. The MA were given on time. Resident had no affi	M, the facility provided a stration Record) MAR as AR showed that all medications. The MAR revealed this ternoon medications all meds morning or evening					
	conducted with the medications were a the DON stated that and 9:00 AM as pri advised that the suit being given at 1:45 wasn't sure how to Administration Records.	PM, an interview was DON. When asked what time idministered to this resident, it they were given at 8:00 AM inted on the MAR. When reveyors had observed meds PM, the DON stated she get the (Electronic Medication ord) EMR printed out. She et a Nurse, who is used to					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION		TE SURVEY MPLETED		
		495423	B. WING		o	3/01/2019		
	ROVIDER OR SUPPLIER  REHABILITATION AN	ID HEALTHCARE	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 658	On 3/1/19 at 4:45F the unit manager. medications were MAR. However wheen made of nursipm, LPN E stated out what the EMAI could do it on the surveyors to use, I got the error mess access to this screen. LPN E then went to printed out the EM what time the med whom.  The following was Medication - Amlotablet by mouth tw 8:00 AM and 8:00 On 2/28/19 the 08:12:21 PM by LPN On 3/1/19 the 08:11:46 PM by LPN AM Lantus Solution (Lunits subcutaneous scheduled for 9:00 On 2/28/19 it was Metformin HCL Tat 1 Tablet by mouth Scheduled for 8:00 AM and 8:00 On 2/28/19 it was	PM, an interview with LPN E, LPN E stated that the giving at the time printed on the men told that observations had be passing medications at 1:45 well let me see if I can print R shows. When asked if she computer given to the LPN E attempted to do so but age "User does not have een."  To a facility computer and AR Report that showed exactly is were signed out and by  Ton the EMAR REPORT:  Diplome (Cardiac Med) - Give 1 to times per day scheduled for PM  Too AM dose was signed off at F  DO AM dose was signed off at Signed off by LPN G at 1:07 AM  Diplome times a day for Diabetes. O AM and 8:00 PM  StOO AM dose was signed off at	F 658					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495423	B. WING_	8 WING		C 03/01/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 7246 FOREST HILL AVE RICHMOND, VA 23225	The state of the s	5/01/2019	
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F 658	On 3/1/19 the 08: 1:46 PM by LPN/ Lisinopril [Cardiac times per day for 8:00 AM and 8:00 On 2/28/19 the 08: 1:221 PM by LPN/ On 3/1/19 the 08: 1:46 PM by LPN/ Metoprolol Tartrat one tablet by mou hypertension schi- On 2/28/19 the 08: 1:46 PM by LPN/ On 3/1/19 the 08: 1:46 PM by LPN/ Spironolactone 5- time per day for H AM and 9:00 PM On 2/28/19 the 08: 1:46 PM by LPN/ On 3/1/19 the 08: 1:46 PM by LPN/ Valproic Acid [Se ML by mouth two Unspecified Convand 9:00 PM On 2/28/19 the 00: 12:21 PM by LPN/ On 3/1/19 the 08: 1:46 PM by LPN/ On 3/1/19 the 08:	OO AM dose was signed off at A  C Med] 20 mg give 1 Tablet 2 two hypertension scheduled at 0 PM 3:00 AM dose was signed off at 1 F 00 AM dose was signed off at A  te 50 MG [Cardiac Med] give uth two times per day for eduled for 8:00 AM and 8:00 PM 8:00 AM dose was signed off at 1 F 00 AM dose was signed off at 1 F 00 AM dose was signed off at 1 A  O MG Give 50 MG by mouth one hypertension scheduled for 9:00 8:00 AM dose was signed off at 1 F 00 AM dose was signed off at 1 F 00 AM dose was signed off at 1 A  Izure Med] Give 15 [Milliliters] Itimes per day related to vulsions scheduled for 9:00 AM 8:00 AM dose was signed off at 1 F 00 AM dose was signed off at 1 F 00 AM dose was signed off at 1 F 00 AM dose was signed off at 1 F	F6	58			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495423	B. WING		C 03/01/2019
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	03/01/2013
BONVIEW	REHABILITATION AND	HEALTHCARE		FOREST HILL AVE HMOND, VA 23225	
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F 658	Continued From pag	e 45	F 658		
	the five rights of med Right client. Right client. Right drug. Right dose. Right time.  On 3/1/19, an interviolation was the time indicate 9:00 AM). When sho stated, oh well I gave just signed them out about the acceptable administration and slighter the medication she was supposed to stated immediately a medicine. LPN A sai wrong but it was fast sign.  The Administrator and this issue during the no further information Free of Accident Haz CFR(s): 483.25(d)(1) \$483.25(d)(1) The reas free of accident his \$483.25(d)(2) Each resupervision and assi accidents.	ew was conducted with LPN time she administered raing, LPN A stated that it ad on the MAR (8:00 AM and own the EMAR Report she emy medications on time. I late. She was then asked time for medication ne stated 1 hour before or is due. When asked when a sign off medications, LPN A fter you see them take the dishe knew her practice was er to pull, pass, and then did the DON were notified of end of day conference and was provided.	F 689	<ol> <li>The crescent wrench a the socket set were immediately removed form the counter at the nurses' station on Mar 1, 2019. The wheel chair for resident #9 March 1, 2019.</li> <li>All residents have potential to be affected An audit was completed to ensure no other residents were affected by this deficiency. No other residents were identified.</li> <li>Maintenance staff was educated on ensuring equipment is secure wond in immediate supervision completed March 1, 2019. All state was educated on 3/5/2019 regarding resident safety with equipment. All clinical staffs were educated the ensure when transportant are applied to wheelch completed on March 2019.</li> </ol>	e ch air neel d. d. d d d d d d d d d d d d d d d d

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER.			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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300000000000000000000000000000000000000	ROVIDER OR SUPPLIER		S1 72	TREET ADDRESS, CITY, STATE, ZIP CODE 246 FOREST HILL AVE ICHMOND, VA 23225	03/01/2019
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 689	documentation revithe facility staff fail environment for the floor (Second Floor ensure a safe envi (Resident # 9) in a staff failed to secu Socket Set left undof the nurses static cognitive abilities in 2. Resident #9 was Physical Therapy pedals/leg rests of the findings included the failed to secu Socket Set left undof the nurses static cognitive abilities in the findings included the failed to secu Socket Set left undof the nurses static cognitive abilities in the failed to secu Socket Set left undof the nurses static cognitive abilities in the failed until 1 several staff meminursing admission walked past and compared with the conducted with the failed with	ation, staff interview, facility view and clinical record review, led to ensure a safe e Residents residing on one or) of three floors and failed to ironment for one resident is survey sample of 11 residents. In the Second Floor, the facility are a Crescent Wrench and attended on the counter (ledge) on, where Residents of various had access  It is being transferred from to his room without foot in the wheelchair.  In the Second Floor, the facility are a Crescent Wrench and access  In the Second Floor, the facility are a Crescent Wrench and attended on the counter (ledge) on, where Residents of various had access  In the Second Floor, the facility are a Crescent Wrench and attended on the counter (ledge) on, where Residents of various had access  In the ledge at the nurses station of the second Floor in the ledge at the nurses station of the second Floor in the ledge at the nurses station of the second Floor in the ledge at the nurses station of the second Floor in the ledge at the nurses station of the second Floor in the ledge at the nurses station of the second Floor in the ledge at the nurses station of the second Floor in the ledge at the nurses station of the second Floor in the ledge at the nurses station of the second Floor in the ledge at the nurses station of the second Floor in the ledge at the nurses station of the second Floor in the second	F 689	4. QI monitoring windone by the DCS/Designee to residents being transported in with have wheel chair applied and ED/D will ensure no maintenance equis left unsupervisit times weekly for month, then one week for two monitoring will be reported to the Ricommittee month period of 3month further compliance revision.  5. Date of Compliance 4/2/2019	ensure heel chair r legs Designee lipment ed three one time per nths. QI e M/QI nly for a s for he and/or

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING _	CONSTRUCTION		ATE SURVEY OMPLETED
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13133413214 3131	ROVIDER OR SUPPLIER	ND HEALTHCARE	72	REET ADDRESS, CITY, STATE, ZIP CO 46 FOREST HILL AVE ICHMOND, VA 23226		
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F 689	nurses station. R staff members on hazards, to which was asked if she seems asked if she seems asked if she seems asked if considered a hazard said "Oh, Maintremoved the wren RN A confirmed the reside on the secs should not have be residents of various to them.  At the end of day Administrator were no further information.  2. Resident #9 we Physical Therapy pedals/leg rests of Resident #9, a 7 the facility 10/5/2 included but were Disease, Tremor, Thrombosis, Ben Urinary Tract Syn Hypertension, Dy Abnormalities of Resident #9's missel) with an Asset 1/12/2019 was con Resident #9's Besident #9's Be	N A was asked if she educated all topics including recognizing she replied "yes". When RN A saw any hazards in the area, nd the vicinity and stated "no." If a wrench and socket set was ard and she replied "Yes." RN enance" and immediately nch and socket set off the ledge. The nat Residents who wander did and floor. RN A stated the tools been left on the ledge where us cognitive abilities had access conference, the DON and the made aware of the issues and ation was provided.  The wheelchair.  It is a being transferred from the proof of the wheelchair.  It is a being transferred from the proof of the wheelchair.  It is a being transferred from the wheelchair.  It is a being transferred from the proof of the wheelchair.  It is a being transferred from the proof of the wheelchair.  It is a being transferred from the wheelchair.	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495423  NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE		IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _ B. WING	00/4/00/00		(X3) DATE SURVEY COMPLETED C 03/01/2019	
		STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225			3/01/2019		
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F 689	# 9 was coded as assistance of one activities of daily li On 3/1/2019 at 3: A) was walking to second floor wher dragging on the flus seconds. When S resident was obsefacility staff persoon the wheelchair pushing the worked for Q pressed the bufloor.  There were other for the elevator, delevator as the sum of the selevator as the sum of the selevator as the sum of the selevator until Empley's room.  On 3/1/2019 at 3: conducted with Ethe elevator on the selevator of	cognitive impairment. Resident needing limited to total staff member to perform his	F 689				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
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F 689	floor. Employee Cobe a bag on the wand causing the sign of the wand causing the several seconds. It was several seconds who was for sure if the rests on the whee Physical Therapy left there. Employ 9's feet were on the elevator and the elevator and the conference row Foot/Leg Rests has 9's wheelchair. Enhad been in the Property of the Carroft.  Review of the Carroft.  Review of the Carroft.  Focus: Potential finafety awareness in functional activity himself onto the fill Goal:(Reside of fall/injury through Interventions inclusions as resident for initiated 10/15/18, Ensure that the resident for the safety aware that the resident for initiated 10/15/18, Ensure that the resident for the safety aware that the resident for initiated 10/15/18, Ensure that the resident for the safety aware that the safety aware that the resident for the safety aware that the safety	dent # 9's feet dragging on the stated sometimes there could theelchair that might be rubbing ound.  ded Employee Q that Resident # erved dragging the floor for Employee Q stated he did not ere were supposed to be leg lichair but he would check the gym to see if the leg rests were ree Q agreed that Resident # the floor while being wheeled to there was a potential for injury.  15 PM, Employee Q came to some to inform the surveyors that ad been applied to Resident # mployee Q stated the leg rests thysical Therapy gym.  Inical Record was conducted on PM.  The Plan revealed documentation for injury/falls related to poor i	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CO 246 FOREST HILL AVE		3/01/2019	
BONVIEW	REHABILITATION AN	D HEALTHCARE	1 19	RICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	mobility The resident needs potential for falls wild distraction  On 3/1/2019 at 4:4' conducted with the P) who stated she had been an issue Assistant (Employer Resident # 9 via wild first floor without for Employee P was in observed to be transwheelchair without Resident # 9 was of feet on the floor with the wheelchair tow floor. Employee P session, some resident muscles to hostated it was not satisfied it was not satisfied it was not satisfied in the feet dragging injuries and accide During the end of administrator and informed of the find being wheeled in the dragging the floor. Director of Nursing Residents to be will floor. Both stated to the resident. The sure the Director of Sales will be the control of the control of the floor.	py) consult for strength and activities that minimize the nile providing diversion and 7 PM, an interview was Director of Rehab (Employee had been informed that there with the Physical Therapist e Q) while he was transporting heelchair in the hallway on the ot/leg rests.  formed that Employee Q was hisporting Resident # 9 via leg rests on the wheelchair beserved to be dragging his hile Employee Q was pushing and the elevator on the first stated as a part of the Therapy dents were encouraged to use lid up their feet. Employee P hife to transport residents with on the floor due to potential for	F 689				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DAT	E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			7246	ET ADDRESS, CITY, STATE, ZIP CODE FOREST HILL AVE HMOND, VA 23225		
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	No further informa Respiratory/Trach CFR(s): 483.25(i)	ty for foot/leg rests while s who tion was provided. eostomy Care and Suctioning	F 689	<ol> <li>Resident # 3 o tubing was im- replaced and a</li> </ol>	mediately a full oxygen	
	tracheostomy care The facility must e needs respiratory care and tracheal care, consistent w practice, the comp care plan, the resis and 483.65 of this This REQUIREME by: Based on observ staff interview and facility staff failed to consistent with infectionsistent with staff esident (Resident Residents).  For Resident # 3, the portable oxyger failed to date the reportable oxygen ta  Findings included: Resident # 3 was the facility on 10/2 but not limited to,	ation, resident interview and clinical record review, the to provide oxygen therapy ection control measures and andards of practice for 1 at # 3) in a survey sample of 11 the facility staff failed to ensure en tank was not empty and masal cannula tubing on the ank.		tank was place residents' room 2019.  2. All residents resovagen therap potential to be An audit was of to ensure no considents were by this deficie other resident identified.  3. All clinically lick was educated oxygen tubing weekly and resaccess to port as requested on March 26,	ed in m March 1, ecceiving by have the e affected. completed bother e affected ncy. No ts were censed staff on ensuring g is changed esidents have table oxygen completed	

		IDENTIFICATION NUMBER: A. BUILD		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495423	B. WING _			03/01/2019	
NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE				STREET ADDRESS, CIT 7246 FOREST HILL A' RICHMOND, VA 23	VE		
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F 695	accidents, depression Depressive disorder. The most recent Min quarterly assessmer Reference Date (AR coded Resident # 3 for Mental Status) so cognitive impairment supervision and set activities of daily living eating, bathing and the supervision with ass for transfer and bed coded as always coron 3/1/2019 at 10:3 facility, as the survey hallway, Resident # nurse, could I please My tank is empty. The hall toward anott Registered Nurse (Registered Nurse (Resident # 3 again so concept and the survey of the hallway two door room, standing in from the preparing medication. The Surveyor went of Resident # 3 again so concept and the bed, oxyliters per minute via oxygen concentrato.	imum Data Set (MDS) was a at with an Assessment D) of 12/5/2017. The MDS with a BIMS (Brief Interview core of 15/15, indicating no t. Resident # 3 required up only assistance with a g for ambulation, dressing, colleting and required istance of one staff person mobility; Resident # 3 was attinent of bowel and bladder.  9 a.m., during tour of the yors were passing in the 3 was heard yelling out "Hey a get a refill of my oxygen? The surveyor walked down her room. A nurse, tN ) C, was observed to be in ris down from Resident # 3's out of the medication cart and	F	4. QIII doi DC res da ox rei th or pe cc pi	monitoring will be ne by the S/Designee to ensure sidents oxygen tubing it ted and portable ygen is available as quested by the residence times weekly for ne month, then one times week for two month I monitoring will be exported to the RM/QI ommittee monthly for eriod of 3months for urther compliance and evision.	nt ne is.	

NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE  BURNIE OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225	1/2019
BONVIEW REHABILITATION AND HEALTHCARE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Inspection of the portable oxygen tank revealed the gauge was in the zone on the far left at zero indicating it was empty. There was oxygen tubing with a nasal cannula attached to the tank. There was no label with a date on the oxygen tubing.  The Surveyor left Resident # 3's room and asked RN C to come to the room. RN C entered the room, talked with Resident # 3' and looked at the oxygen tank's gauge. RN C stated "okay, I will get another tank for you."  RN C returned with another portable oxygen tank. The Oxygen tank was replaced by RN C who showed the surveyor the tank gauge was then reading the tank was registering at 1000. RN C removed the tubing from the empty tank and placed it on the new tank.  Resident # 3 said "That tank is almost empty too. It doesn't have much oxygen in it." RN C stated "I know. But that's the fullest one I could find." Resident # 3 stated "That's not going to last me very long because I get 4 liters a minute. RN C stated "I know. I will call and get some more tanks delivered."  On 3/1/2019 at 10:40 a.m., an interview was conducted with Resident # 3 who stated he had been asking for a full oxygen tank all night long, but the staff did not change the tank. Resident # 3 stated the staff "were busy but I need my oxygen so I can go to the bathroom and move around my room."  On 3/1/2019 at 1:30 p.m., observed oxygen tanks being delivered by the Oxygen supply company.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUIA. AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED
		495423	B, WING _			03/01/2019
NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225			
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	Administrator and D informed of the issu oxygen tank and no the portable tank. The noticed that the portable oxygen tank went to Resident #3 she immediately chait with a date. The Adid have extra oxygavailable for use. The facility received "del Friday and always of facility needed. The should have oxygen and the tubing shout the facility's policy who changed every S.  No further information Residents are Free CFR(s): 483.45(f)(2)  The facility must ensemble the facility must ensemble of 11 residemedication errors.  This REQUIREMENT by:  Based on observated documentation the facility is a sample of 11 residemedication errors.  1. For Resident #2 administer Cardiac,	irector of Nursing were es of the empty portable date on the oxygen tubing on the Director of Nursing stated oxygen tubing on the k was not dated when she as room. The DON stated anged the tubing and labeled administrator stated the facility en tanks that were full and he Administrator stated the ivery of oxygen tanks every ordered more tanks" than the DON stated Resident # 3 a available in the portable tank lid be dated. The DON stated vas that oxygen tubing was to sunday on night shift.  On was provided, of Significant Med Errors ) sure that its- ents are free of any significant  IT is not met as evidenced ion, staff interview and facility facility staff failed to ensure idents # 2 and # 7) in a survey ints were free from significant the facility staff failed to Diabetic and Seizure ered by physician. The	F 6	1.	Resident # 2 and #7 we assessed for adverse reaction none were identified, provider an responsible representative were notified March 1, 2019 All residents have the potential to be affected. An audit was complete to ensure no other residents were affected by this deficiency. No other residents were identified. All clinically licensed stawas educated on medication administratic completed on March 2, 2019.	d d. ed d aff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  495423		(X2) MULTIPLE O	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	495423	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	03/01/2019
BONVIEW REHABILITATION AND HEALTHCARE			724	18 FOREST HILL AVE CHMOND, VA 23225	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION:	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 760	2. For Resident # doses of anti-seizi Tegretol) and two Anxiety at the sam Findings Included	7, the facility staff gave two ure medications (Depakote and doses of Clorazepate for ne time on 3/1/2019 at 5:52 AM.	F 760	4. QI monitoring will be done by the DCS/Designee to ensure proper medication administration three times weekly for one month, then one time p	per
	administer Cardial medications as on medications were Resident #2, a 59 to the facility on 13 limited to muscle (falls, insomnia, str	1. For Resident # 2 the facility staff failed to administer Cardiac, Diabetic and Seizure medications as ordered by physician. The medications were administered late  Resident #2, a 59 year old woman, was admitted to the facility on 12/4/18 with diagnoses of but not limited to muscle weakness fatigue, history of falls, insomnia, stroke, major depressive disorder, diabetes, hemiplegia, and Hemiparesis following stroke.		week for two months. monitoring will be reported to the RM/QI committee monthly for period of 3months for further compliance and revision.  5. Date of Compliance: 4/2/2019	a
	Resident #2's most recent (Minimum Data Set) MDS (screening tool) coded as an admission assessment dated 2/22/19 coded the Resident as having a (Brief Interview of Mental Status) BIMS of 13 indicating mild cognitive impairment.  On 3/1/19 at 1:45 PM an observation was of LPN C passing medications to residents.  During clinical Record review it was noted that Resident # did not have medications due at that time.  On 3/1/19 at 4:30 pm, the facility provided a (Medication Administration Record) MAR as requested. The MAR showed that all medications were given on time. The MAR revealed this Resident had no afternoon medications and that				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495423  NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE		IDENTIFICATION NUMBER: A. BUILI		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		TE SURVEY MPLETED C
		STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225			03/01/2019	
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F 760	all medications we medications.  On 3/1/19, an inter DON. When asked administered to this given at 8 am and When advised that surveyors had obs 1:45 PM. The DO to get the (Electron Record) EMAR pri would get a Nurse and using the EMA On 3/1/19 at 1645 manager, she statthe time printed or that observations I passing medication me see if I can pri When asked if she given to the survey so and got the erro have access to this LPN E then went to printed out the EMA what time the medication.  The following was Medication - Amlo Give 1 tablet by mischeduled for 8:00	re morning or evening  view was conducted with the d what time medications were s resident she stated they were 9 am as printed on the MAR. It the MAR was incorrect as erved meds being given at N stated she wasn't sure how nic Medication Administration inted out. She stated she who is used to giving meds AR system to try.  an interview with LPN a unit ed that the meds were giving at in the MAR however when told had been made of nurse ins at 145 pm she stated well let int out what the EMAR shows. It could do it on the computer yors to use she attempted to do or message "User does not	F7	60		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495423		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	CO	TE SURVEY MPLETED  C 3/01/2019	
NAME OF PROVIDER OR SUPPLIER BONVIEW REHABILITATION AND HEALTHCARE			72	REET ADDRESS, CITY, STATE, ZIP COE 246 FOREST HILL AVE ICHMOND, VA 23225		0.0112010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(XS) COMPLETION DATE
F 760	PM.  Lantus Solution (Liunits subcutaneou scheduled for 9:00 On 2/28/19 it was AM.  Metformin HCL Tail 1 Tablet by mouth Scheduled for 8:00 On 2/28/19 the 08:12:21 PM by LPN On 3/1/19 the 08:013:46 By LPN A.  Lisinopril [Cardiac Tablet 2 two times scheduled at 8:00 On 2/28/19 the 08:12:21 PM by LPN On 3/1/19 the 08:013:46 By LPN A.  Metoprolol Tartrate give one tablet by hypertension sche PM. On 2/28/19 the 08:12:21 PM by LPN	ong acting Insulin) Give 50 sly at bedtime for Diabetes PM. signed off by LPN G at 01:07  Diet 1000 [Milligrams] MG Give two times a day for Diabetes. D AM and 8:00 PM. O0 AM dose was signed off at F. D AM dose was signed off at Medication] 20 mg give 1 per day for hypertension AM and 8:00 PM. C00 AM dose was signed off at F. D0 AM dose was signed off at F. D0 AM dose was signed off at F. D0 AM dose was signed off at E. D0 AM dose was signed off at	F 760			
	time per day for H AM and 9:00 PM.	MG Give 50 MG by mouth one ypertension scheduled for 9:00 :00 AM dose was signed off at F.				

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03/01/2019
ZIP CODE
W OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423		(X2) MULTIPLE ( A. BUILDING  B. WING	CONSTRUCTION	Co	ATE SURVEY DMPLETED  C 03/01/2019		
NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			724	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	12/5/2018 was code assessment. Reside a BIMS (Brief Intervor of 15 out of 15 indicand was able to madecisions. Resident limited to extensive member to perform including transfers, Resident # 7 was coand ambulation.  On 3/1/2019 at 11:5 record for Resident. Review of the Medic (MAR) for March 20 medications that we The MAR revealed one medication due observed to be adm (Depakote 500 milli All of the other med Resident # 7 were as morning (6 AM of evening medication were PRN (as need on 3/1/2019 at 12:2 conducted with RN not have a "nerve padministration with RN C stated she gas scheduled at 9 AM night shift had giver pill" to Resident # 7	sessment reference date) of ad as an admission ent # 7 was coded as having iew of Memory Status) Score ating no cognitive impairment ke her own daily life t # 7 was coded as requiring assistance of one staff her activities of daily living toileting, hygiene and bathing, oded as independent in eating, oded as independent in eating, as some staff her activities of the clinical with the staff her activities of daily living toileting, hygiene and bathing, oded as independent in eating, and the staff have conducted.  Some staff her administration Record to the staff have a summarized ha	F 760				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C		
		495423 B. V			0	03/01/2019	
2610104143011	NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CO 7246 FOREST HILL AVE RICHMOND, VA 23225	DDE		
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 760	Record) MAR as MAR showed that time.  Review revealed PM on 2/28/2019 given on 3/1/2019 the medications with time on 3/1/2019 - Clorazepate 7.5 every 8 hours for - Depakote 500 mevery 6 hours for - Tegretol 200 miles for administration Tegretol were: Clorazepate 7.5 every 8 hours for (Scheduled 6 AM Depakote 500 miles every 6 hours for (Scheduled 6 AM Depakote 500 miles every 6 hours for (Scheduled 6 AM Midnight) Tegretol 200 mills for Seizures (Scheduled 6 AM Midnight) Tegretol 200 mills for Midnight for Seizures (Scheduled 6 AM Midnight) Tegretol 200 mills for Seizures (Scheduled 6 AM Midnight) Tegretol 200 mills for Seizures (Scheduled 6 AM Midnight) Tegretol 200 mills for Seizures (Scheduled 6 AM Mi	ch (Medication Administration requested. The March 2019 t all medications were given on medications scheduled for 10 and 3/1/2019 at 6 AM were both 3 at 5:52 AM. The two doses of were administered at the same	F7	60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		495423	B. WING		0	C 03/01/2019	
	ROVIDER OR SUPPLIER  FREHABILITATION AND	HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
37377-377	importance of adheric medication administration administration and informed of the finding documented on the finding documented on the finding given on time whour after the schedul Nursing stated the examedications should be hour before and one time. The Director of should administer methodications and the finding finding finding from the finding f	ng to the standards of ation during orientation of ell.  I day debriefing on 3/1/2019, I Director of Nursing were gs of medications being Medication Administration red on time but actually not within one hour before or one ided time. The Director of spectation was that e administered within one hour after the scheduled Nursing stated nurses adications as ordered by the in was provided, dentifiable Information 483.70(i)(1)-(5)  Int-identifiable information that is a the public, becase information that is an agent only in intract under which the agent disclose the information he facility itself is permitted	F 760	1. Resident # 2, #3, #4 #6 and #7 were ass for adverse reactio were identified, pre and responsible representative were notified March 1, 2	essed in none povider  re 2019. the ected. pleted r ected No ere ed staff dications on the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495423	B. WING		C 03/01/2019
	ROVIDER OR SUPPLIER REHABILITATION AND	HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 842	all information containegardless of the form records, except where (ii) To the individual, or representative where (iii) Required by Law; (iii) For treatment, part operations, as permit with 45 CFR 164,506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purpurposes, research purpurposes, rese	ented; e; and ganized  ility must keep confidential ned in the resident's records, n or storage method of the release is- or their resident permitted by applicable law; yment, or health care ted by and in compliance cactivities, reporting of abuse, violence, health oversight administrative proceedings, boses, organ donation purposes, or to coroners, uneral directors, and to avert ealth or safety as permitted with 45 CFR 164.512.  Ility must safeguard medical gainst loss, destruction, or  I records must be retained required by State law; or the date of discharge when ent in State law; or ars after a resident reaches	F 842	4. QI monitoring will be done by the DCS/Designee to ensu proper medication administration and documentation are completed three times weekly for one month then one time per wee for two months. QI monitoring will be reported to the RM/Q committee monthly for period of 3months for further compliance and revision.  5. Date of Compliance: 4/2/2019	s , ek U or a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495423		IDENTIFICATION NUMBER:	A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  C 03/01/2019		
	ROVIDER OR SUPPLIER  / REHABILITATION A	ND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 842	(iii) The comprehe provided; (iv) The results of and resident revie determinations co (v) Physician's, nu professional's profe	any preadmission screening we evaluations and inducted by the State; arse's, and other licensed gress notes; and diology and other diagnostic is required under §483.50. ENT is not met as evidenced vation, staff interview, and liew, the facility staff failed to accurate clinical record esidents # 2, # 3, # 4, # 5, # 6, # urvey of 11 residents.  2, the facility failed to accurately medication administration on tion Administration Record).  3, the facility staff failed to curate time medications were  4 4, the facility failed to the time of medication the MAR (Medication ecord).  4 5, the facility failed to the time of medication the MAR (Medication ecord).  4 6, the facility failed to the time of medication the MAR (Medication ecord).	F 843				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423	(X2) MULTIPLE ( A. BUILDING  B. WING	CONSTRUCTION	co	(X3) DATE SURVEY COMPLETED  C 03/01/2019	
	ROVIDER OR SUPPLIER	ID HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842	accurately record to administration on the Administration Record. Resident (Resident record.)  7. For Resident #3 record the time of the MAR (Medication Record)  1. For Resident #2 record the time of the (Medication Accurate) facility on 12/4/18 limited to muscle with the facility of 13/1/19 at 1:45 C passing medical During clinical Records.	7, the facility failed to he time of medication he MAR (Medication cord) and; and Progress Notes for another it # 11) filed in the clinical  8, the facility failed to accurately medication administration on a dministration Record).  9 the facility failed to accurately medication administration on administration on administration Record).  9 the facility failed to accurately medication administration on administration on administration on administration Record).  9 the facility failed to accurately medication administration on administration on administration on administration record (Minimistration of Section 1) of the weakness fatigue, history of oke, Major depressive disorder gia and Hemiparesis following  10 trecent (Minimum Data Set) (Minim	F 842				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED C	
	NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE		B. WING	STREET ADDRESS, CITY, STATE, ZIP 7246 FOREST HILL AVE RICHMOND, VA 23225		03/01/2019	
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 842	On 3/1/19 at 4:30 Medication Admir requested. MAR were given on timhad no afternoon morning or evening or evening on 3/1/19 an interport of they were given at the MAR. When incorrect as survergiven at 1:45 PM sure how to get the Administration Report of the manager was the meds were given at 1:45 pm, LPN E see in the EMAR When asked if she given to the survergiven to the	pm, the facility provided the histration Record (MAR) as showed that all medications he. MAR revealed this Resident medications all meds wereing medications.  Inview was conducted with the ed what time medications were his resident, the DON stated that at 8 am and 9 am as printed on advised that the MAR was eyors had observed meds being the DON stated she wasn't he (Electronic Medication ecord) EMAR printed out. The she would get a Nurse who is eds and using the EMAR system, for pm, an interview with LPN E as a conducted. LPN E stated that the she would that observations had hurse passing medications at stated, well let me see if I can what time they were given.  The could do it on the computer eyors to use, LPN E attempted the error message "User does"	F 8-	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
						03/01/2019	
	NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE		7	TREET ADDRESS, CITY, STATE, ZIP CO 246 FOREST HILL AVE ICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	Continued From pa	age 66	F 842				
		d however the EMAR e actual time the meds were					
		ne end of day meeting the DON were made aware of this ion was provided.					
	accurately record t	3, the facility staff failed to he time of medication he MAR (Medication cord).					
	the facility on 10/2 but not limited to, 3 Pulmonary Diseas Chronic Pain Syno	a 61-year-old male admitted to 5/2017 with the diagnoses of, Severe Chronic Obstructive e, Sarcoidosis, Hypertension, Irome following multiple car sion and anxiety, Major er.					
	quarterly assessm Reference Date (A coded Resident # for Mental Status) cognitive impairme supervision and se activities of daily li eating, bathing an supervision with a for transfer and be	finimum Data Set (MDS) was a ent with an Assessment (MDS) of 12/5/2017. The MDS 3 with a BIMS (Brief Interview score of 15/15, indicating no ent. Resident # 3 required et up only assistance with ving for ambulation, dressing, d toileting and required essistance of one staff person and mobility; Resident # 3 was continent of bowel and bladder.					
	conducted with Re facility was always	:20 AM, an interview was esident # 3 who stated the working short of staff. d he received his medications					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF A. BUILDING 495423 B. WING				(X3) DATE SURVEY COMPLETED C	
	ROVIDER OR SUPPLIER	100000000000000000000000000000000000000	S1 72	STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842	late the night before stated he did not go but was supposed is tated he was upset his breathing medic stated he had 4 lite still was short of breathing was short of breathing as I can breath Review of the clinic 3/1/2019 at 11:30 A Review of the Febradministration Recommedications being 2/28/2019. There is administration of most recommedications being 2/28/2019 at 1:1 conducted with the Registered Nurse (should be passed in hour after the scheen RNA A stated RN (approximately 3 with all new nurses receive 3 days of days on the floor was a stated for the scheen RNA of the scheen RNA and the schee	e (2/28/2019). Resident # 3 et his medication until 11 PM to get it at 9 PM. Resident # 3 et because he needed to get cations on time. Resident # 3 ers of oxygen per minute and eath because of COPD. I "I need my medicines on the."	F 842				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495423	B. WING			03/01/2019		
	ROVIDER OR SUPPLIER REHABILITATION AN	ID HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 842	Development Nurs floor. RN A stated about medication a orientation. RNA A standard was for numedications within after the scheduled that "all nurses shown as saked to orientation topics of C. The list of topic orientation was not to the end of the seconducted with the MAR showed the MAR showed the administered at 9 lists was informed that received his medical 2/28/2019. When of the EMAR (Elect Administration Received his medical 2/28/2019. When of the EMAR (Elect Administration Received his medical control of the EMAR (Elect Adm	e or any other nurse on the RN C received the information administration during her stated the professional nursing urses to administer one hour before and one hour ditime of administration and buld know that."  It is provide a copy of the covered with Registered Nurse is covered during RN C's to provided to the surveyor prior urvey.  If PM, an interview was a Director of Nursing who stated the medications were PM as scheduled. The DON Resident # 3 reported that he cations 2 hours late on the DON was asked for a copy	F 84	2				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495423	B. WING _		0	C 03/01/2019	
	ROVIDER OR SUPPLIER  REHABILITATION AN	ID HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 7246 FOREST HILL AVE RICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	Medication Administration on the surveyors to use, Lifeport and got the chave access to this would try one of the then went to a facility EMAR Report denomedications were aby whom.  On 3/1/2019 at 2:00 of the EMAR report "Administration Hismedications documedications do	stration Record). When LPN E build access the EMAR computer given to the LPN E attempted to retrieve the error message "User does not s screen." LPN E stated she e facility's computers. LPN E lity computer and printed he oting the exact times each administered, signed out and  2 PM, LPN E presented a copy t. Review of the EMAR story Report" revealed mented as administered on time AR were actually administered  2 PM Breath Activated cosol Powder Breath	F8	142			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495423  (X2) MULTIF A. BUILDING B. WING		PLE CONSTRUCTION  3	co	(X3) DATE SURVEY COMPLETED  C 03/01/2019	
	ROWDER OR SUPPLIER	ID HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225			
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F 842	Abuse-Deterrent 2 mouth every 12 ho Syndrome Schedu 2/28/2019 at 22:58 2/28/2019 at 23:18 Senna Capsule 8.6 by mouth at bedtin at 9 PM 2/28/2019 at 22:58 2/28/2019 at 23:18 Tylenol 325 milligr hours for pain Sch PM 2/28/2019 at 23:18 On 3/1/2019 at 23:14 2/28/2019 at 23:18 On 3/1/2019 at 5 I reported that Potte used by the facility guidance. The DC expected to use the Administration.  Guidance for profit the administration.  Guidance for profit he administration.  Guidance for profit he administration.  Fundamentals of Potter-Perry, p. 76 such as the Ameri Nursing: Scope a Practice (2004) apadministration. To follow the six right medication errors an inconsistency i medication administration administra	ed Release 12 hour 0 milligrams give one tablet by eurs related to Chronic Pain led 9 AM and 9 PM 8 (10:58 PM) documented 9 (11:18 PM) 6 milligrams give one capsule ne for constipation Scheduled 8 (10:58 PM) documented 9 (11:18 PM) eams Give 3 tablets every 8 eduled at 6 AM, 2 PM and 10	F 84	42			

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423	(X2) MULTIPLE CONSTRUCTION A BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  C 03/01/2019		
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	Medications -Oral A Procedures Effective Revision Date: 9/22 revealed: "Chart on Medication (MAR) according in medication is given next resident."  During the end of the Administrator and Dinformed of the find documented on the Record as administation administration adm	edication ose ent ute ne	F 84				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495423	B. WING		0	3/01/2019
	ROVIDER OR SUPPLIER  / REHABILITATION AN	D HEALTHCARE	7	STREET ADDRESS, CITY, STATE, ZIP CO 246 FOREST HILL AVE RICHMOND, VA 23225	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X6) COMPLETION DATE
F 842	of morning medical signed by LPN B.  On 3/1/2019 at 8:1. Progress Notes wa nurses notes revea 3/1/2019 at 19:56 ( (Medical Doctor/Re of morning medical signed by Register.)  No further informated as in the facility record the administration on the Administration Record the facility on 10/10 but not limited to: Chypoglycemia. De Polyneuropathy.  The most recent Medical quarterly assessment Reference Date (Acoded Resident #4 for Mental Status) cognitive impairmed limited assistance activities of daily lib bathing. Resident set up only for eating staff person for ball staff person for ball signed assistance activities of daily lib bathing. Resident set up only for eating staff person for ball staff person for ball signed assistance activities of daily lib bathing. Resident set up only for eating staff person for ball staff pers	ions administered late."  5 PM, a copy of the Nurses s presented. Review of the led documentation on 7:56 PM) that "MD/RP esponsible Party) made aware tions administered late." ed Nurse (RN) B. ion was provided.  4, the facility staff failed to the time of medication ne MAR (Medication	F 842			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	col	TE SURVEY MPLETED  C 3/01/2019		
	ROVIDER OR SUPPLIER	D HEALTHCARE	72	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225				
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F 842	Review of the Medirevealed document administered on time and the initials of the medications in the series of the was no document administration of medications of the Nurse 3/1/2019 revealed administration of medication of the MAR showed the MAR showed the administered as social asked for a copy of Medication Administrated she was not of the EMAR report of the EMAR report.  On 3/1/19 at 1:45 Feronducted with the Practical Nurse (LF and stated that the time printed on the would see if she could see if she could be a see if	al record was conducted on M.  cation Administration Record ation of all medications being ite. There were check marks e nurses administering the slots for scheduled times. mentation of late edications on the MAR.  es Notes from 2/1/2019 to no documentation of late edications. The last Nurses 9 at 17:05 (5:05 PM) stating	F 842					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED
		495423	B. WING _		0	C 3/01/2019
	ROVIDER OR SUPPLIER	ND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 7246 FOREST HILL AVE RICHMOND, VA 23225		0.0 1,2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE
F 842	report and got the have access to thi would try one of the then went to a facilities. EMAR Report den medications were by whom.  On 3/1/2019 at 2:0 of the EMAR report according to the Mark r	LPN E attempted to retrieve the error message "User does not some some facility's computers. LPN E lity computer and printed he oting the exact times the administered, signed out and to 2 PM, LPN E presented a copy of the Review of the EMAR story Report" revealed mented as administered on time IAR were actually administered in the IAR	F	342		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILDI		MULTIPLE CONSTRUCTION  JILDING		(X3) DATE SURVEY COMPLETED C	
		495423	B. WING		(	3/01/2019	
7.0000000000000000000000000000000000000	ROVIDER OR SUPPLIER	D HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225				
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F 842	Continued From page	ge 75	F 842				
	Medications -Oral A Procedures Effective Revision Date: 9/22 revealed: "Chart on Medication (MAR) according immedication is given next resident."  During the end of the find documented on the Record as administ being given on time hour after the scheduled time stated the expectat should be administrand one hour after Director of Nursing administer medication was On 3/1/2019 at 8:19 Progress Notes was nurses notes reveal 3/1/2019 at 19:56 (Medical Doctor/Residue).	5 PM, a copy of the Nurses is presented. Review of the alled documentation on 7:56 PM) that "MD/RP is ponsible Party) made aware administered late and by RN B.					

	PETICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423		CONSTRUCTION	cor	TE SURVEY MPLETED  C 3/01/2019
	ROVIDER OR SUPPLIER  REHABILITATION AN	D HEALTHCARE	- 7	TREET ADDRESS, CITY, STATE, ZIP CO 246 FOREST HILL AVE RICHMOND, VA 23225	DDE	
(X4) IO PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 842	accurately record the administration on the Administration Record to the facility on 1/3 but not limited to, Destrapyramidal and Gastroesophageal Major Depressive Land Vitamin Deficies.  The most recent M 30 day assessment Reference Date (A coded Resident # 8 for Mental Status): cognitive impairment extensive assistant activities of daily living Review of the Clinical 3/1/2019.  Review of the Mark Administration Record administered on 3/1 check mark indicated administered. The late administration of administered during Registered Nurse medications to Resident # 8 for Mental Status):	5, the facility staff failed to be time of medication of MAR (Medication ord).  79-year-old female admitted 5/2019 with the diagnoses of, biabetes, Schizophrenia with movement disorder, Reflux Disorder, Hypertension, Disorder, Pacemaker, Anemia. Procy.  inimum Data Set (MDS) was a twith an Assessment RD) of 1/31/2019. The MDS 5 with a BIMS (Brief Interview score of 15/15, indicating no nt. Resident # 5 required ce of one staff person with	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A, BUILDI		MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
	ROVIDER OR SUPPLIER	495423	ST	REET ADDRESS, CITY, STATE, ZIP C		3/01/2019	
BONVIEW	REHABILITATION A	ND HEALTHCARE	R	CHMOND, VA 23225			
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F 842	administration of Note was from Ac (1:30 PM) stating Note:(Resident participate in grous pending time in friendly conversal Signed by Activition the Activities note 2/21/2019 at 1:50 On 3/1/2019 at 1:40 On a Computer of the EMAR repiget a Nurse who medications and retrieve the report on 3/1/2019 at 1:40 Conducted with the Practical Nurse (and stated that the time printed on the RN C was observed and the actual times EMAR (Electroni Record). When access the EMA given to the survertieve the report User does not held the set of the survertieve the report of the surve	medications. The last Progress stivities on 2/22/2019 at 13:30 "Participation dent # 5) does not wish to up programs and enjoys room watching tv. She likes tion at times. No concerns. es Director. The note prior to was a Skilled Nurse Note dated AM.  35 PM, an interview was be Director of Nursing who stated the medications were scheduled. When the DON was of the EMAR (Electronic distration Record) report, she of sure of how to obtain a copy out. The DON stated she would was familiar with giving using the EMAR system to try to	F 842				

		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495423	B. WING _	<del>_</del>	0	C 03/01/2019	
	ROVIDER OR SUPPLIER	ND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225				
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(XS) COMPLETION OATE	
F 842	computers. LPN Ecomputer and printhe exact times the administered, sign On 3/1/2019 at 2:0 of the EMAR repo "Administration Himedications docuraccording to the Mat the times noted Aspirin EC (Enterimilligrams one tab Scheduled at 9 Af 3/1/2019- adminis Atorvastatin 40 mimouth one time a Scheduled at 9 Af 3/1/2019- adminis Buspirone 5 millig time a day for maj Scheduled at 9 Af 3/1/2019- adminis Loratadine 10 millitime a day for Alle 3/1/2019- adminis Miralax 17 grams related to constipa 3/1/2019- adminis Tramadol 50 millig every 12 hours for PM	Ethen went to a facility ted he EMAR Report denoting e medications were ed out and by whom.  22 PM, LPN E presented a copy rt. Review of the EMAR story Report" revealed mented as administered on time MAR were actually administered  c Coated) Delayed Release 81 elet by mouth one time a day.  M tered at 12:03 PM  Illigrams give one tablet by day for Hyperlipidemia M tered at 12:03 PM  rams one tablet by mouth one or depressive disorder.	F.8	42			

	INT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A, BUILDING  495423 B. WING		co	(X3) DATE SURVEY COMPLETED  C 03/01/2019		
	ROVIDER OR SUPPLIER	9100000000		STREET ADDRESS, CITY, STATE, ZIP CO 7246 FOREST HILL AVE RICHMOND, VA 23225		3/01/2019
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR USC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 842	Zoloft 25 milligram time a day, for Ma Scheduled at 9 AM 3/1/2019- adminis Review of the Fac Medications - Oral Procedures Effect Revision Date: 9/2 revealed: "Chart on Medicat (MAR) according medication is give next resident."  During the end of Administrator and informed of the fir documented on the Record as adminibeing given on tim medications listed than the schedule stated the expects should be administrator and one hour after by the physician. correct time the months of the physician of	is give one tablet by mouth one for Depressive Disorder of tered at 12:03 PM illity Documentation on Administration Policies and ive Date: 11/30/2014 and 22/2017 on page 1 of 2 ion Administration Record mmediately [sic] following when an and before proceeding to the the day debriefing, the Director of Nursing were dings of medications being are Medication Administration stered on time but actually not ne within the parameters of istration of within one hour after the scheduled time. The lawere given three hours later and time. The Director of Nursing atton was that medications stered within one hour before are the scheduled time as ordered and should document the nedications were administered.  15 PM, a copy of the Nurses are presented. Review of the scaled documentation on (7:57 PM) that "MD/RP Responsible Party) made aware tion of morning meds	F 84			

X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423	A. BUILDING	ONSTRUCTION	col	TE SURVEY MPLETED  C 3/01/2019	
EALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225				
MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
was provided.  The facility staff failed to facility staff failed to facility staff failed to failed the failed to failed the failed t	F 842				
		### ### ### ### ### ### ### ### ### ##	EALTHCARE  EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTENT OF DEFICIENCY  BOOK TAG DEPTITION OF DEFICIENCY  THE PROVIDER'S TAG DEPTITION OF DEFICIENCY  BOOK TAG DEPTITION OF DEFICIENCY  THE PROVIDER'S TAG DEPTITION OF DEFICE OF TAG DEPTITION OF THE	### A BUILDING  ### A BUILDING	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495423	B. WING			3/01/2019
	ROVIDER OR SUPPLIER	) HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225		
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F 842	Continued From pag	ge 81	F 84	2		
		the time the nurse, RN) C was observed passing dent # 6 on 3/1/2019.				
	Review of the Nurse documentation of la medications.	es Notes revealed no te administration of				
	Nurse (LPN) E pres report. Review of th History Report" reve documented as adm	PM, Licensed Practical ented a copy of the EMAR ne EMAR "Administration ealed medications ninistered on time according stually administered at the				
		[T] 34 (TR. 1920) NOWNELL				
		257 (179 (179 ) . A (179 (179 ) ) (179 (179 ) ) (179 ) (179 )				
		red at 11:17 AM				
	Lisinopril 10 milligra	ams give one tablet by mouth Hypertension Scheduled at 9				

		CORRECTION IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION  JILDING		(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225			3/01/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE	
F 842	mouth one time a day AM 3/1/2019 administer 2/28/2019 administer Review of the Facilit Medications -Oral A Procedures Effective Revision Date: 9/22 revealed: "Chart on Medication (MAR) according immedication is given next resident."  During the end of the find documented on the Record as administrator ar informed of the find documented on the Record as administration after the scheduled time stated were given must be in the scheduled time stated the expectation should be administer and one hour after Director of Nursing administer medication was  On 3/1/2019 at 8:15	ed at 11:17 AM  pred at 10:39 AM  prams give one tablet by ay for Diabetes Scheduled at  ed at 11:17 AM  pred at 10:39 AM  ty Documentation on dministration Policies and e Date: 11/30/2014 and /2017 on page 1 of 2  an Administration Record amediately [sic] following when and before proceeding to the  and Director of Nursing were and Director of Nursing were and on time but actually not a within one hour before or one duled time. The medications ore than one hour later than The Director of Nursing ion was that medications ered within one hour before the scheduled time. The stated nurses should ions as ordered by the Id document the correct time	F 842				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BU			2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 246 FOREST HILL AVE RICHMOND, VA 23225		3/01/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 842	3/1/2019 at 20:10 (in (Medical Doctor/Re of morning medicat signed by RN C.)  No further information of the Administration on the Administration Records of the Administration Resident (Resident #7 had Resident	led documentation on 3:10 PM) that "MD/RP sponsible Party) made aware ions were administered late."  on was provided.  7, the facility failed to be time of medication and; de Progress Notes for another # 11) filed in the clinical  60 year old female, was ity 11/28/18. Resident # 7's but were not limited to: Neoplasm of the uterus, by Anemia, Edema, Bariatric and Anxiety Disorder.  recent MDS (minimum data assessment reference date) of	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ON IDENTIFICATION NUMBER: A. E		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		TE SURVEY MPLETED
	ROVIDER OR SUPPLIER		S 7	TREET ADDRESS, CITY, STATE, ZIP O 246 FOREST HILL AVE ICHMOND, VA 23225		3/01/2019
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F 842	On 3/1/2019 at 11 record for Resider On 3/1/19 at 12:5(a copy of the Mark Record) MAR as in MAR showed that time.  Review of Reside documentation on Administration Relevetiracetam, Lowere given on time checkmarks indicadministered on the documentation of late administration.  Further review of Clorazepate 7.5 in hours was not sold AM. It was scheded hours at 6 AM, 2.  Review of the Pronotes documenting medications. The Activities on 2/22 "Participation Not participates as to no concerns" Since the proof of the pronotes documenting at 14:44 milligrams was series at 14:44 milligram	:55 AM, review of the clinical int # 7 was conducted.  D PM, the facility staff provided the (Medication Administration requested. The March 2019 all medications were given on the #7's clinical record revealed the March 2019 Medication record that medications (Lasix, poratadine, Potassium Chloride) the at 9 AM. There were ating medications were time. There was no missing medications or any indication of	F 842			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED C - 03/01/2019		
NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225			3/01/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	Nurse (LPN) E presereport. Review of th History Report" rever documented as admit to the MAR were act times noted:  Review revealed me PM on 2/28/2019 and given on 3/1/2019 at Documentation show medications were git 3/1/2019 at 5:52 PM.  Clorazepate 7.5 mill every 8 hours for Ge Depakote 500 milligrates for Seizures  Medications schedul 3/1/2019 at 9 AM were Docusate Sodium 11 mouth one time a day Administered 3/1/20 Lasix 40 milligrams a day for edema Levetiracetam 750 milligrams and day for sease Potassium Chloride milliequivalents give time a day Vitamin D 50000 un one time a day ever	ented a copy of the EMAR e EMAR "Administration aled medications inistered on time according tually administered at the edications scheduled for 10 d 3/1/2019 at 6 AM were t 5:52 AM. wed two doses of these ven at the same time on it igrams one tablet by mouth eneralized Anxiety Disorder rams one tablet by mouth ery 6 hours for Seizures ims by mouth every 8 hours led to be administered on ere administered at 11:31 AM 00 milligrams one tablet by ay scheduled at 9 AM 19 at 11:31 AM one tablet by mouth one time milligrams one tablet by mouth Epilepsy rams one tablet by mouth one	F 84	2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495423  NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE		IDENTIFICATION NUMBER: A. BUI		(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING		TE SURVEY MPLETED C
		STREET ADDRESS, CITY, STATE, ZIP CODE  7246 FOREST HILL AVE  RICHMOND, VA 23225			03/01/2019	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 842	Procedures Effecti Revision Date: 9/2 revealed: "Chart on Medicati (MAR) according i medication is give next resident."  During the end of the Administrator a informed of the fin documented on th Record as adminis being given on tim hour after the sche listed were given on the scheduled time stated the expecta should be adminis and one hour after Director of Nursin administer medication was on 3/1/2019 at 8: Progress Notes w nurses notes reve 3/1/2019 at 20:01 (Medical Doctor/R of morning medications and should be at other "argumentative at should be at other	Administration Policies and ve Date: 11/30/2014 and 2/2017 on page 1 of 2  Ion Administration Record mediately (sic) following when and before proceeding to the steed on time but actually not be within one hour before or one eduled time. The medications more than one hour later than be. The Director of Nursing within one hour before or one eduled time. The medications more than one hour later than be. The Director of Nursing within one hour before or the scheduled time. The grated within one hour before or the scheduled time. The grated within one hour before or the scheduled time. The grated nurses should within a copy of the Nurses as presented. Review of the aled documentation on (8:01 PM) that "MD/RP desponsible Party) made aware actions administered late."	F8	42		
	No further informa	ation was provided.				

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495423	B. WING		0	3/01/2019	
	ROVIDER OR SUPPLIER	HEALTHCARE	72	REET ADDRESS, CITY, STATE, ZIP CODE 46 FOREST HILL AVE CHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	6b. After the survey copies of the Physic clinical information fincluded in the copie Review of Physician Resident # 7 reveals Progress Note dateresident that was not Resident was assig (Resident # 11) in the Progress Note for Resident # 11 was a diagnoses of but no Diabetes, and End 9 Progress Note was physician on 2/5/20  7. For Resident # 9, a 72 y the facility 10/5/201 included but were no Disease, Tremor, C Thrombosis, Benigr Urinary Tract Symp Hypertension, Dysa Abnormalities of Garesident # 9's most Set) with an Assess 1/12/2019 was code.	rended, further review of the clans Progress Notes revealed for another resident was as from Resident # 7's record.  Its Progress Notes for a two-paged Physicians of 1/29/2019 for another of in the survey sample. That ned a number to be identified his documentation. Review of or Resident # 11 revealed as 64 year old female with the limited to: Hypertension, Stage Renal Failure. The signed electronically by the 19.  Ithe facility staff failed to be time of medication ord).  In the facility staff failed to be time of medication ord).  In the facility staff failed to be time of medication ord).  In the facility staff failed to be time of medication ord).  In the facility staff failed to be time of medication ord).  In the facility staff failed to be time of medication ord).  In the facility staff failed to be time of medication ord).  In the facility staff failed to be time of medication ord).  In the facility staff failed to be time of medication ord).  In the facility staff failed to be time of medication ord).  In the facility staff failed to be time of medication ord).	F 842				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PPLETED
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F 842	Status) Score was indicating severe of # 9 was coded as assistance of one activities of daily life Review of the clini 3/1/2019 at 4:30 P.  Review of the MAI Record) revealed on time on 2/28/20 check mark indica administered. The late administration on 3/1/2019 at 5:10 A presented a copportive EMAR "Administered on time actually administered on time actually admin	coded as a 6 out of 15 cognitive impairment. Resident needing limited to total staff member to perform his ving.  Ical record was conducted on PM.  R (Medication Administration medications were administered 19 and 3/1/2019. There was a ting the medications were ere was no documentation of of medications.  10 PM, Registered Nurse (RN) by of the EMAR report. Review ministration History Report" ons documented as me according to the MAR were red at the times noted: ms give 0.5 tablet by mouth d at bedtime for d at 8 AM and 9 PM 019 at 9 PM, administered M Iligrams one tablet by mouth at lipidemia 019 at 9 PM, administered M Opa 25-100 milligrams give four hree times a day for se 019 at 10 PM, administered	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  3		E SURVEY PLETED
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35,000	ROVIDER OR SUPPLIER	ND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP C 7246 FOREST HILL AVE RICHMOND, VA 23225		0012013
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F 842	Carbidopa-Levodo 25-100 milligrams for Parkinson's Dis Scheduled 2/28/2 3/1/2019 at 1:32 A Gabapentin 100 m mouth every 8 hor Hyperplasia Scheduled 2/28/2 3/1/2019 at 1:32 A Oxybutynin Chloriby mouth every 8 Hyperplasia Scheduled 2/28/2 3/1/2019 at 1:32 A Senna 8.6 milligrated bedtime for Const Scheduled 2/28/2 3/1/2019 at 1:32 A Monitor vital signs Scheduled 2/28/2 3/1/2019 at 1:32 A The documentatic actual time the abadministered.  During the end of the Administrator informed of the fir documented on the Record as adminibeing given on times a scheduled given on times and the scheduled of the fir documented on the Record as adminibeing given on times a scheduled given on times given on times given on times and given on times given given on times given gi	opa ER (Extended Release) one tablet by mouth at bedtime sease 019 at 9 PM, administered M  milligrams give one capsule by urs for Benign Prostatic 019 at 9 PM, administered M  de 5 milligrams give one tablet hours for Benign Prostatic 019 at 9 PM, administered M  ams give two tablet by mouth at ipation 019 at 9 PM, administered M  severy 12 hours 019 at 9 PM, documented	F 84	42		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUIL		(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED
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NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 7246 FOREST HILL AVE RICHMOND, VA 23225			×
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AU DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	the scheduled time, stated the expectation should be administed and one hour after to Director of Nursing administer medication physician and shout the medication was No further information Prevention CFR(s): 483.80(a)( §483.80 Infection Confection prevention designed to provide comfortable environd development and tradiseases and infection program.  The facility must estand control program a minimum, the foll §483.80(a)(1) A systems and control program a minimum, the foll §483.80(a)(1) A systems and control program a minimum, the foll §483.80(a)(1) A systems and control program a minimum, the foll §483.80(a)(1) A systems and control program a minimum, the foll §483.80(a)(1) A systems and control program a minimum, the foll §483.80(a)(1) A systems and control program a minimum, the foll §483.80(a)(1) A systems and control program a minimum, the foll §483.80(a)(1) A systems and control program a minimum, the foll §483.80(a)(1) A systems and control program a minimum, the foll §483.80(a)(1) A systems and control program a minimum, the foll §483.80(a)(1) A systems and control program a minimum.	The Director of Nursing on was that medications ared within one hour before the scheduled time. The stated nurses should ons as of dered by the ld document the correct time administered.  on was provided.  a. & Control  1)(2)(4)(e)(f)  control  tablish and maintain an and control program as a safe, sanitary and ment and to help prevent the ransmission of communicable tions.  In prevention and control  stablish an infection prevention (IPCP) that must include, at owing elements:  stem for preventing, identifying,	F 84		e nurses' d in the n March the fected. pleted er fected . No ere	
	reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards.  §483.80(a)(2) Written standards, policies, and			and CNA) was edu on ensuring nebul placed in the soile room after use Ma 2019.	icated lizers are ed utility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495423	8 WING		0	C 3/01/2019	
NAME OF PROVIDER OR SUPPLIER  BONVIEW REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 7248 FOREST HILL AVE RICHMOND, VA 23225				
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F 880	procedures for the probut are not limited to.  (i) A system of surve possible communical infections before they persons in the facility (ii) When and to who communicable diseas reported;  (iii) Standard and trait to be followed to preview (iv) When and how is resident; including but (A) The type and dur depending upon the involved, and  (B) A requirement the least restrictive possicircumstances.  (v) The circumstance must prohibit employ disease or infected sontact with resident contact will transmit (vi) The hand hygiene by staff involved in displaying the system of th	illance designed to identify one diseases or a can spread to other in materials of the possible incidents of the procedure of infections in the isolation of the isolation, infectious agent or organism at the isolation should be the oble for the resident under the procedure of the disease; and the disease; and the procedures to be followed the procedures to be followed the isolation, infectious agent or organism at the isolation should be the oble for the resident under the procedure of the disease; and the disease; and the procedures to be followed the procedures to be followed the procedure of the facility.  If the process, and the the process, and the procedure of the process of the procedure of the	F 880	4. QI monitoring for residents requiring nebulizers, as well a nebulizer equipmen be done by the DCS/Designee to enter nebulizers are place the soiled utility root after us three times weekly for one monthen one time per with for two months. QI monitoring will be reported to the RM/committee monthly period of 3 months further compliance revision.  5. Date of Compliance 4/2/2019	t, will sure d in m th, reek /QI for a for and/or		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		VC00000136	ON NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		0.0000000000000000000000000000000000000		03/01/2019		
	ROVIDER OR SUPPLIER  REHABILITATION A	ND HEALTHCARE	72	REET ADDRESS, CITY, STATE, ZIP CODE 46 FOREST HILL AVE CHMOND, VA 23225		
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F 880	Continued From p	age 92	F 880			
F 880	IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to maintain infection control practices for Residents residing on one floor (Second Floor) of three floors  1. For Residents on the Second Floor, the facility staff failed to properly store a used nebulizer machine left unattended on the counter (ledge) of the nurses station, where Residents of various cognitive abilities had access.  The findings include:  1. For Residents on the Second Floor, the facility					
	machine left unatt the nurses station cognitive abilities	erly store a used nebulizer ended on the counter (ledge) of , where Residents of various had access. :45 AM during initial tour noted				
	2 used nebulizer r nurses station not	nachines on the counter at the covered or placed in plastic were left on counter until 11:55				
	conducted with RI Education Nurse) any Residents on answered, yes we if the two nebulize clean and she sta asked where the	5 AM, an interview was N A (Infection Control /Staff . When asked if the facility had the unit that wandered she have two. She was then asked ers on the counter were dirty or ted "They look dirty." When dirty equipment should be ting disinfection she stated, the				

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	495423 B. WING					
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 7246 FOREST HILL AVE RICHMOND, VA 23225		
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F 880	aware of where the stored she stated  On 3/3/19 the end Administrator were	She was asked if staff were ne dirty equipment should be	F 8			